DOCUMENT RESUME

ED 245 137 CG 017 507

TITLE	Alcohol and the Elderly. Hearing before the Subcommittee on Health and Long-Term Care of the Select Committee on Aging. House of Representatives, Ninety-Eighth Congress, First Session (June 10, 1983, Astoria, N.Y.).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
PUB DATE	Jun 83
NOTE	58p.; Some pages may be marginally reproducible due to small print.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Aging (Individuals); *Alcoholism; Drinking; Financial Support; Gerontology; *Health Needs; Hearings; *Intervention; *Older Adults; Prevention
IDENTIFIERS	Congress 98th; *Long Term Care

ABSTRACT

The proceedings of the Congressional hearing on alcohol and the elderly are presented. Following introductory statements by the committee chairman, Senator Claude Pepper, and Representatives Mario Biaggi and Geraldine Ferraro, the briefing paper, "Crisis in Health Care Part 2: Alcoholism," prepared by the subcommittee staff is presented. Issues addressed include demographics, the dimensions of the problem, alcoholism and aging, treatment, medicaid and medicare funding, and adequacy of current resources. Statements of witnesses are provided including those of Jason Robards; Bishop Sullivan, head of Catholic Charities for Brooklyn; Helen Hernandez, from Embassy Tandem Communications; a panel representing the Manhattan Bowery Corporation; a panel representing the New York City Committee on Women and Alcohol; a panel representing Substance Abuse Services and the Research Institute on Alcoholism; and Don Nicholson, from the Department of Health and Human Services. Topics covered include advertising, the alcoholic personality, community issues and efforts, the entertainment industry's role in social issues, health needs, treatment programs, psychosocial aspects of alcoholism, sex differences, drug abuse and drug/alcohol interactions, alcohol-related problems, and medicare coverage for treatment programs. (BL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ALCOHOL AND THE ELDERLY

ED245137

7/30

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

JUNE 10, 1983, ASTORIA, N.Y.

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 98-406

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

X This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

CG 017507

U.S. GOVERNMENT PRINTING OFFICE
28-356 O WASHINGTON : 1984

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
IKE ANDREWS, North Carolina
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN N. LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
GERALDINE A. FERRARO, New York
BEVERLY B. BYRON, Maryland
WILLIAM R. RATCHFORD, Connecticut
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
DONALD JOSEPH ALBOSTA, Michigan
GEO. W. CROCKETT, JR., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
FREDERICK C. (RICK) BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
TOM VANDERGRIFF, Texas
ROBERT E. WISE, JR., West Virginia
BILL RICHARDSON, New Mexico

MATTHEW J. RINALDO, New Jersey
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
JUDD GREGG, New Hampshire
GEORGE C. WORTLEY, New York
HAL DAUB, Nebraska
LARRY E. CRAIG, Idaho
PAT ROBERTS, Kansas
COOPER EVANS, Iowa
JIM COURTER, New Jersey
LYLE WILLIAMS, Ohio
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
MICHAEL BILIRAKIS, Florida
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey

JORGE J. LAMBRINOS, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

CLAUDE PEPPER, Florida, *Chairman*

IKE ANDREWS, North Carolina
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
MARILYN LLOYD, Tennessee
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
WILLIAM R. RATCHFORD, Connecticut
BUTLER DERRICK, South Carolina
RON WYDEN, Oregon
GERALDINE A. FERRARO, New York
HENRY A. WAXMAN, California
BRUCE F. VENTO, Minnesota
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
EDWARD R. ROYBAL, California
(Ex Officio)

RALPH REGULA, Ohio,
Ranking Republican Member
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
HAL DAUB, Nebraska
LARRY E. CRAIG, Idaho
PAT ROBERTS, Kansas
JIM COURTER, New Jersey
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
MICHAEL BILIRAKIS, Florida
MATTHEW J. RINALDO, New Jersey
(Ex Officio)

BILL HALAMANDARIS, *Staff Director*
KATHLEEN GARDNER CRAVEDI, *Assistant Staff Director*
JAMES P. OBERLE, Ph. D., *Minority Staff Director*

CONTENTS

MEMBERS' OPENING STATEMENTS

	Page
Chairman Claude Pepper	3
Geraldine A. Ferraro	1
Mario Biaggi	5
"Crisis in Health Care," briefing paper by staff of Subcommittee on Health and Long-Term Care, submitted by Chairman Claude Pepper	8

CHRONOLOGICAL LIST OF WITNESSES

Jason Robards	15
Bishop Sullivan, head of Catholic Charities for the Diocese of Brooklyn	20
Helen Hernandez, director, Public Affairs for Embassy Tandem Communications	21
Panel one:	
George McNamara, New York	24
John Reinhart, New York	25
Jeremiah Sheehan, New York	27
Elizabeth Kiernan, director, Nursing Services, Manhattan Bowery Corp	28
Panel two:	
Dorothy Phelan, chairwoman of the New York City Committee on Women and Alcoholism, New York	33
Karl Nelson, executive director of Bird S. Coler Hospital, New York	39
Panel three:	
Marguerite Saunders, deputy director, Division of Substance Abuse Services, State of New York	42
Dr. Phillip Zeidenberg, acting director, Research Institute on Alcoholism, Buffalo, N.Y	44
Don Nicholson, Assistant Inspector General, Department of Health and Human Services, Washington, D.C	47

ALCOHOL AND THE ELDERLY

FRIDAY, JUNE 10, 1983

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
Astoria, N.Y.

The subcommittee met, pursuant to call, at 9 a.m., at the Astoria Community Senior Citizen Center, 2356 Broadway, Astoria, N.Y., Hon. Claude Pepper (chairman of the subcommittee) presiding.

Members present: Representatives Pepper of Florida, Biaggi of New York, and Ferraro of New York.

Staff present: Bill Halamandaris, staff director, Kathleen Gardner Cravedi, assistant staff director, of the Subcommittee on Health and Long-Term Care. Kevin Donnellan, office of Congresswoman Geraldine Ferraro.

Ms. KENNEDY. Ladies and gentlemen, it is a great privilege and a great honor to be holding this congressional hearing on alcoholism and how it affects the elderly in our society.

It is also a great honor to have Senator Claude Pepper, Congresswoman Geraldine Ferraro, and Congressman Mario Biaggi with us this morning.

Alcohol is a disease which affects people physically, spiritually, and mentally, and this hearing is in keeping with the program we have going on here at the Astoria Community Center Catholic Charities. So we welcome our various dignitaries. Would you give them a big hand?

And now I will turn the hearing over to our dynamite Congresswoman Geraldine Ferraro.

OPENING STATEMENT OF REPRESENTATIVE GERALDINE A. FERRARO

Ms. FERRARO. Thank you. I, first of all, want to thank Janet and the Astoria Community Senior Citizen Center, for hosting this hearing for us this morning. You are all my friends, and for this reason we come back here often.

I would like to welcome all of you to the hearing this morning of the Select Committee on Aging, Subcommittee on Health and Long-Term Care. And, as you know, today's hearing will focus on alcohol and the elderly.

Alcohol is the biggest problem in the substance abuse area among the elderly. Records show that up to 56 percent of the elderly hospital admissions are alcohol related. I find this number absolutely shocking. Obviously it has a significant impact on health-

care costs and what is happening to our medicare and medicaid system.

To understand the problem of the elderly alcoholic, I think it is important that we talk about what is happening to the elderly in our society.

Nobody really knows what causes some people to become problem drinkers. We can identify, however, some of the forces that drive people to drink.

Retirement is one problem which worries many elderly workers. For many retirement is a feeling of emptiness and financial uncertainty. Retirement can drive people to drink.

Our culture is a youth-oriented society and we do not give the elderly, oftentimes, the respect they deserve. The feeling that they are not valued by society can drive people to drink.

A large segment of our elderly population lives in poverty. In fact, the poverty rate for persons 65 and over was almost 16 percent in 1980, higher than 13 percent of the general population. Another 2.5 million or 10 percent of the elderly were classified as near poor. In total one-fourth of the older population were poor or near poor in 1980.

In addition to living in poverty, nearly one-third of our elderly live alone. Research has shown that the most important therapy for elderly alcoholics is social. These people respond quickly to the company of their peers and purposeful rehabilitation. Obviously, poverty and loneliness can drive people to drink.

We must recognize in dealing with the problem of alcohol and the elderly, that 25 percent of all prescription drugs are consumed by those 65 years of age and older. Many of the drugs are known to interact adversely with alcohol. Therefore, the importance of both public and physician education becomes obvious.

The House Select Committee on Aging and its subcommittees often conduct hearings in the field, as we are doing today. These hearings allow us to receive testimony from people who may otherwise be unable to come to Washington and testify before a congressional committee. I am pleased that Chairman Pepper has given me the opportunity to hear about the problems of alcohol and the elderly in this community. I am also delighted that he and my colleague, Mario Biaggi, are here with us today.

I am looking forward to the testimony of the witnesses, but before that occurs, I would like to ask my two colleagues to make opening statements.

You do not need an introduction to Congressman/Senator Claude Pepper, chairman of the Health Subcommittee of the Aging Committee of the House, former chairman of the Aging Committee and now chairman of the most powerful committee in the House, the Rules Committee.

Mr. PEPPER. Thank you.

Ms. FERRARO. So often people say to me, "How are things down in Congress?" And I just love it so. Part of the reason I do, and one of the most important reasons is because I work with some very fine people. I work with some people who care more about this Nation than you could ever imagine. And one of those people is Claude Pepper.

I think what you have seen over the past several years in his fight to protect the rights of the elderly is just a small piece of the work that he does for this country. And I know that you do not need any form of further introduction. You are one of the people I consider one of the heroes of the House, Senator/Congressman Claude Pepper.

OPENING STATEMENT OF CHAIRMAN CLAUDE PEPPER

Mr. PEPPER. Thank you very much. Such a beautiful speech being made by such a beautiful lady, I wish she would just keep on. I would be glad to waive my time.

I am profoundly grateful this morning to have the privilege of being here with all of you. I remember being here with Mayor Koch last year, and I remember very pleasantly my visit with many of you who are here today.

I am particularly pleased to be able to be here with one—can you hear me? Let me start over.

First, I want to express my profound pleasure in being here with all of you this morning. I remember having been here during the campaign last year and I remember very pleasantly that visit. I am glad to see some of you here today whom I recognize as having seen on that occasion. And Ms. Kennedy who does such a fine job as your director, was here, I recall very vividly, at that time.

I am especially pleased to be able to be here with two of the great Members of Congress. Not only one of the great ladies of Congress, but one of the great Members of Congress, Ms. Geraldine Ferraro. She is one of the most prominent Members of the House of Representatives, one of the most influential, and one of the most highly respected. And so it is with great particular pleasure to be here with her in her district, and to be with you to talk about a matter that is so meaningful to all of the senior citizens of this country.

Now, I am only 82 years old, if you do not think I am old enough to be here. I tell them I stay so busy, I do not have time to get old. And I hope all of you are doing the same thing.

I am particularly pleased to be able to be here with the Honorable Mario Biaggi. He is one of my dearest friends in the House of Representatives. He is a member of one of the most important committees in the House of Representatives. He is one of the most respected and influential Members of the House. And he is now the second ranking person in seniority on the overall Aging Committee. I remained on the Select Committee as chairman of the Subcommittee on Health and Long-Term Care. And Ms. Ferraro is a member of that subcommittee.

Mr. Biaggi is chairman of his own very important subcommittee and has done a magnificent job for the elderly of this country as chairman of that committee.

I wonder if I may take just a minute. I want to tell a little story since you have three Congress Members here, a little story I heard about a bishop and a Congressman who went to heaven at the same time.

They were met at the Pearly Gates by St. Peter, and he said, "Come in, and I will show you all where you are going to live while

you are here." Shortly, he opened a door and he said, "Mr. Bishop, you go in here. This is where you will live." The bishop noticed it was a very small room, but he did not know anything else to do so he accepted the invitation and entered.

Then St. Peter said, "Mr. Congressman, you come on down a little further." He opened up another door and said, "This is where you will live." The Congressman walked in and looked around and said, "My, my, St. Peter, this big, beautiful suite. I am so glad to have it. Thank you very much."

Meanwhile the bishop had gotten a little suspicious wondering whether St. Peter was going to prefer the Congressman over him. And so he slipped up there at the first opportunity and looked in. There it was, that big, beautiful suite with a lovely view.

Well, it just burnt the poor bishop up. And he hunted up St. Peter. He said "St. Peter, you just have not treated me right." He said, "I spent nearly all my life down on Earth working for the Lord and the church. Now I come up here and you give me a little cubbyhole and you give that Congressman a big, beautiful suite. That just is not fair."

St. Peter tapped the bishop on the shoulder and said, "Bishop, do not feel that way about it. There are bishops all over heaven, but that is the first Congressman we have ever had."

One of the subjects with which we are especially concerned is the problem of alcoholism among the elderly of the country. And we are holding hearings all over the country to consider that very serious problem.

Alcoholism is the third most prevalent disease in this country. Twelve to fifteen million Americans are alcoholics or have serious drinking problems. Thirty-five million more are affected by alcoholism indirectly. Alcohol has been implicated in half of all homicides, half of all automobile accidents, one-quarter of all suicides, and 40 percent of all divorces. Economic cost associated with alcoholism exceeds $120 billion a year.

Alcohol is particularly a problem of the elderly. Incidentally, you know, once the elderly lose their jobs, they have more trouble, more difficulty in getting another job than any other part of the population. Today, for example, there are 775,000 people over 55 years of age who are looking for a job. But there are 334,000 who have given up hope and have quit looking for a job. Those are the people who too often become the victims of alcoholism, sometimes of heart attacks, and sometimes of suicide.

So alcoholism is particularly a problem of the elderly. Widowers over the age of 75 have the highest rate of alcoholism in the country. At least 10 percent of the elderly have an alcohol problem. The prevalence of this problem is compounded by the fact that physiological changes connected with age result both in a lower tolerance for alcohol and an increase in its toxic effects.

Alcoholics, many of whom are seniors, account for one out of every four patients admitted to hospitals. Most of them suffer debilitating illnesses, exacerbated by their use of alcohol. Nevertheless, for many, social stigma and lack of specific insurance coverage induces inappropriate hospital use, when treatment could be provided just as effectively in less costly surroundings, for example, in the home.

Ninety percent of the $150 million in medicare spent for alcoholism in 1982 went for institutional care. The remainder was paid to physicians. Costs associated with at least some of these programs approach $300 a day. Some outpatient and community programs have proven equally successful at about one-tenth of the cost.

We must also begin to address the question of whether it is for a purpose to treat the disease or its related medical manifestation. Hospital beds are filled with patients suffering from gastrointestinal, cardiovascular, and other orthopedic problems that result from alcohol abuse.

Up to 70 percent of what are truly alcohol-related problems are masked by surrogate diagnoses. Heavy users of alcohol average $1,372 more per year in medical care than nonalcoholics. A recent report to Congress from the Office of Technological Assessment, estimates the total per capita cost of alcoholics to society is about $10,000 a year. If even that part of the total could be recovered, by even moderately effective treatment programs, significant reductions in these social and economic health costs could be achieved. A greater savings would be possible if programs were improved toward equally effective, but less costly, treatment programs.

Our review indicates there is an obvious need to develop a more efficient treatment program for alcoholism. We are anxious to hear the witnesses here today before us to see what views they can offer to us. If such a system can be developed, it is less likely that services will be denied to those who need them or that costs will be prohibitive. So we are expecting to hear some very valuable suggestions from this distinguished company here today.

Thank you very much.

Ms. FERRARO. I would like now to turn the microphone over to my other colleague in the House who is here today. Mr. Biaggi needs no introduction to you, people, since until the last redistricting, he represented some of you. He is no longer in Queens, however, and now represents the Bronx. But we do miss him.

Let me also add that Mario has been a member of the Aging Committee since it was started, and he is also chairman of the Human Services Subcommittee on that committee, and I am delighted to welcome him back to Astoria.

STATEMENT OF REPRESENTATIVE MARIO BIAGGI

Mr. BIAGGI. Thank you very much, Geraldine, Congressman Pepper, ladies, and gentlemen. I will make my statement short because Congresswoman Ferraro and Congressman Pepper have already given you the basic statistics and it serves no purpose for me to repeat them. They are an established fact. It is a problem to be confronted, and it is one that must be met. This hearing today is a significant first step in addressing the problem that most people do not recognize is as extensive as it really is. Though we are having the hearing here in Astoria, it is a problem that affects every community in the United States.

It is estimated there are some 2.5 million people who suffer from alcohol abuse. Clearly, the elderly face a crisis in health care. Despite the fact that a recent Presidential commission report noted that 25 percent of our Nation's elderly are suffering from mental

28-356 O - 84 - 2

health problems, the report also states that there is not any money being appropriated to provide these services for the elderly. That is another area that should be addressed. Many of those mental health problems develop as a result of alcoholism, which has in its base, poverty, isolation and loneliness.

When we talk about congregate settings and senior centers, the benefits of them extend far beyond what seems to meet the naked eye. If we had more centers and more social activities, there would be fewer elderly that would be afflicted with the disease of alcoholism.

Just last week, the American Association for the Advancement of Science revealed that life expectancy will jump more than 3 years to 74 for men and 86 for women by the year 2000. Now, this statistic has major economic and social implications for the health of the elderly. Alcohol may be the only companion to these growing numbers of elderly who find themselves alone.

Let me make one observation that has not been made. I think it is critical. It is something which the media of our Nation can address and can be very helpful. To date we have found that the mass media, electronic, as well as the printed media, have been very cooperative and very essential in our efforts to deal with the problems of the elderly.

One of the notions I have is that while we have many advertisements and many documentaries dealing with alcohol and the consequences of it, we invariably find young people and middle-aged individuals being portrayed as victims or the culprits. On the other hand, you may have some elderly being the victims.

I think it is important for the media to portray the fact that we have elderly who are suffering from alcoholism, so that the elderly of our Nation are aware that they have contemporaries, their contemporaries, who are suffering from this malady. They should be conscious of it, and direct attention to the resolution of the problem. So far this particular element has been virtually neglected. That is why it is so critical and so important that Geraldine has had this hearing today. It is something we would rather not talk about, but if you sweep it under the rug, you will never clean the house. I think it is salutary that we have it out in the open, out in front.

I would suggest that the mass media henceforth bring forth the notion that we have some 2.5 million elderly who are suffering from alcoholism and portray some of them, in the conditions they are, the conditions that cause it, and focus attention on it so that not only will the people at large be responsive, but the senior community itself will be aware of the problem and put it on the agenda. It belongs there with every one of the concerns the elderly have enumerated so far.

It is as important as nutrition. It is important as housing. It is important as any other element. If I told you it was cancer, you would jump and scream and yell, "Let us do something about it." Well, in a sense it is cancer. It is cancer of the mind, and you are talking about the deterioration, the degeneration of an individual who might otherwise enjoy life as you and I who are not afflicted.

So with this hearing we are looking forward to some of the testimony and we will have some experience from those who have made

it back and how, and from those professionals who will make their contribution. More importantly, the hearing will accomplish what I feel is critical, and that we will embark on a crusade to meet the problem and hopefully resolve it. Thank you.

[The prepared statement of Representative Biaggi follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARIO BIAGGI

I am honored to join with our most distinguished colleague and Chairman of this Subcommittee, Mr. Pepper, and my good friend and valued colleague, Geraldine Ferraro, at this morning's hearing on the subject of "Alcoholism and the Elderly." Let me also say that it is great to be back in Astoria—a part of which I was proud to represent in Congress between 1972 and 1982.

Let us be right up front about this subject—alcoholism is a very real problem which our Nation's elderly face today. It is true that we have selected Astoria for this hearing—but it is a problem faced by people of every town and county across this Nation. Our Committee estimates that nearly 10 percent of the elderly population of this Nation—more than 2.5 million people—suffers from some form of alcohol abuse. However, the most tragic consequence of alcoholism can ofttimes be measured by its devastating impact upon the mental health of its aged victims. A Presidential Commission has told us that as many as 25 percent of our Nation's elderly suffer from mental health problems—many are related to alcohol. Even worse—the General Accounting Office recently issued a report noting that mental health services for the elderly within communities are virtually non-existent. Clearly, the elderly face a crisis in health care—and our attention to this very special problem today will guide us towards solutions tomorrow.

The factors which produce alcoholism among the elderly are as varied as our population itself. However, we are aware of the fact that the highest rate of alcoholism in this Nation is found in widowers over 75. This suggests that isolation and loneliness—long a problem among elderly citizens—is contributing to the rising tide of elderly alcoholics.

Demographics compel us to look for solutions now—to avert a generation of geriatric alcoholics later. We know that for the first time in history—there are more Americans over 60 than under 10. The fastest growing segment of our elderly population—one-third—are those living alone. Just last week, the American Association for the Advancement of Science revealed that life expectancy will jump more than three years by the end of this decade—to 74 for men and 86 for women. This statistic has major economic and social implications for the long-term health of the elderly. Alcohol may be the only companion to those growing numbers of seniors who find themselves alone.

We must come to grips with alcoholism among the elderly—not by our usual methods of waiting for the disease to strike before we act—but through preventative care. One of the most unfortunate policy decisions proposed by the President and ratified by Congress eliminated a number of categorical programs aimed at combating alcoholism. They were replaced by the alcohol, drug abuse and mental health block grant. Prior to the block grant, combined federal funding for these three areas was $519 million. After the creation of the block grant, funding was slashed to $432 million where it has remained frozen for two years. A modest increase of $30 million was provided in the House Budget Resolution. Obviously, much more is needed not only in terms of funding but also greater visibility of programs within the federal structure. The problem of alcoholism is a fundamental national health problem which does not deserve to be blended in with other concerns.

Let me also concur with the Chairman on his observation that we need to provide more funds for Medicare for preventative care for at-risk seniors with alcohol problems. It is shocking to me that 90 percent of the $150 million we spend for the treatment of alcoholism under Medicare is for institutional care—when the problem has reached its most acute stage. We should be spending more for prevention—where we will ultimately be spending less.

Finally, let me make one observation. I commend the media of this Nation for their broadcasting and television public service announcements spotlighting the problems associated with alcohol abuse. Whether it be in discussions of drunk driving—or family abuse—these ads are powerful tools in our Nation's battle against this disease. However, these ads are remiss in their failure to include elderly people. Older people are more prone to watch television or listen to the radio. Therefore, ads which involve their contemporaries might have an even greater and more deterrent impact. I call upon the Advertising Council and all those associated with these

advertisements to recognize the intergenerational aspects of this problem and have this reflective of future public service announcements.

I join in welcoming our witnesses today and look forward to hearing the testimony.

Mr. PEPPER. Before we hear our witnesses, I would like to submit for the record a briefing paper prepared by the staff of the subcommittee, dealing with the disease of alcoholism. Hearing no objection, so ordered.

[The briefing paper submitted by Chairman Pepper follows:]

CRISIS IN HEALTH CARE—PART 2: ALCOHOLISM

BRIEFING PAPER PREPARED BY THE STAFF OF THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE, HOUSE SELECT COMMITTEE ON AGING, JUNE 10, 1983

I. INTRODUCTION

Historically, those who suffer from alcoholism have been the subject of ridicule, amusement and contempt. Though many of these reactions linger, increasingly we have come to recognize the problem of alcohol abuse as a disease, rather than a violation of social mores. Alcoholics, formerly condemned for their fragile willpower and self-destructive tendencies, are now largely perceived as the victims of an illness.

With this increased awareness, a variety of social and medical programs have evolved to help alcoholics and stem their rising numbers. Despite these efforts, the economic and social costs incurred by those afflicted with the disease remain a pressing policy concern.

Twelve to fifteen million Americans are alcoholics. Alcoholics comprise one in four patients admitted to hospitals. Most of them suffer debilitating illnesses exacerbated by their alcohol abuse that result in particularly costly lengths of stay. Nevertheless, for many an undiminished social stigma and lack of specific insurance coverage induces inappropriate hospital use, when treatment could be provided just as effectively in less costly settings, Current reliance on the hospital care setting reflects, to a large degree, our nation's bias toward the traditional medical model—doctors, nurses, and hospitals—when perhaps the greatest treatment benefits in this area may come from counseling and rehabilitation rather than physiological intervention.

In contrast, various lower cost, alternative treatment modalities have shown considerable success. In the forefront of the low cost modalities, is Alcoholics Anonymous, a way of life as well as a treatment regimen that is practiced in 22,000 groups serving more than 400,000 members across the country. Between the two extremes of Alcoholics Anonymous and the inpatient hospital setting lie a number of other treatment settings, including storefront social service programs, outpatient therapy sessions, inpatient and freestanding centers, and behavior modification programs practicing aversive conditioning. Associated costs range from $285 per day for treatment provided in 28-day inpatient programs to $17-35 per day for equally successful "recovery homes."

In addition, the policy debate is further confused by the question of whether it is more cost effective to treat alcoholism or the related medical problems often cited to disguise the primary disagnosis. Hospital beds are filled with patients suffering from gastrointestinal, cardiovascular, nervous, and orthopedic problems that result from alcohol abuse. Proponents of targeted treatment programs maintain that overall health care costs are reduced when alcoholics are treated specifically for drinking problems. In fact, an alcohol abuser is said to use an average of $1,372 more per year in medical care services than a non-abuser. Up to 70 percent of the cases involving alcohol are said to be masked by surrogate diagnosis.

As the debate continues, the problem worsens. A quarter of a million people develop drinking problems every year, with serious increases now being noted among teenagers, white collar workers, physicians, and women. A patchwork quilt of alcohol intervention and treatment programs exist, with an array of resources being offered at local, state, and federal levels of government as well as by the private sector. Nevertheless, the sum of these efforts appears to be inadequate to the task at hand. Some estimate that up to 85 percent of the nation's problem drinkers are receiving no form of treatment at all.

II. DIMENSION OF THE PROBLEM

About two thirds of the adult population (66 percent of women and 77 percent of men) report at least occasional use of alcohol. Per capita consumption in this country averages about 2.6 gallons per year.

While social use of alcohol is common, a minority (about 10 percent) consume more than half the total. These individuals are considered problem drinkers and heavy users. Most are alcohol dependent or in some stage of alcoholism.

Alcoholism is the third most prevalent disease in the country. Twelve to 15 million Americans are either alcoholic or have serious problems directly related to the abuse of alcohol. Up to 35 million more individuals are estimated to be affected indirectly. Although estimates are imprecise, alcoholism and alcohol abuse have been implicated in half of all automobile accidents, half of all homicides, and one-quarter of all suicides. Alcohol abuse is a major factor in divorce and accounts for perhaps 40 percent of all problems brought to family courts.

The economic cost of alcoholism and alcohol abuse, a major portion of which is lost work productivity, may be as high as $120 billion annually. Furthermore, alcohol abuse may be responsible for up to 15 percent of the nation's health care costs. Alcoholics use significantly greater amounts of medical services than do nonalcoholics for a wide range of physical problems caused by or associated with excessive drinking.

Alcohol (ethanol)—especially when consumed in large quantities or habitually—is related to various health problems such as organ damage (particularly, the liver), brain dysfunction, cardiovascular disease, and mental disorders. It has a significant effect on mortality rates. In general, the life expectancy of alcoholics is 10 to 12 years shorter than average. Cirrhosis of the liver, a direct result of long-term alcohol consumption, is currently the fourth leading fatal disease in the United States. When other effects of alcohol abuse are counted, alcoholism is an even more significant mortality factor. In addition, alcoholics have significantly higher suicide rates than do nonalcoholics (up to 58 times greater in some groups of alcoholics) and accident rates that are significantly greater than normal. Each of these factors results in a significant number of deaths for individuals who abuse alcohol at all age levels. In terms of morbidity, it has been estimated that alcoholic patients comprise from 30 to 50 percent of all hospital admissions, excluding obstetrics. While these admissions are most often for other disorders, alcoholism complicates the patients' recovery.

The following list contains the most frequent alcohol associated medical conditions:

1. Pneumonia.
2. Gastritis.
3. G.I. bleeding.
4. Pancreatitis.
5. Siginficant Trauma—particularly head trauma and burns.
6. Electrolyte Imbalance.
7. Infection.
8. Anemia—severe.
9. Diabetes mellitus, uncontrolled.
10. Neuromuscular disease.
11. Hepatitis.
12. Malnutrition.
13. Laennec's disease.
14. Cardiac disease.
15. Other underlying psychiatric problems.

Alcoholism and aging

Seniors with alcohol problems are roughly divided into two categories: those with a history of "problem drinking" and those whose later onset of alcoholism and alcohol problems is linked to specific conditions associated with age. Among the factors contributing to the problem of alcoholism among the elderly are the following:

Seniors are more likely to encounter situations that are known to contribute to an onset of problem drinking. Retirement, unrewarding increased leisure, and physical and social isolation are all potential threats to the maintenance of self esteem. These situations may trigger destructive behaviors such as problem drinking.

Similarly, in later life, people are more likely to encounter grief and loneliness. The death of a spouse, family member or close friend has been cited as contributing to drinking problems. Since nearly twice as many women survive beyond age of 65 as do men, women may be particularly vulnerable to the onset of alcoholism as a result of loneliness and grief. Professional opinions indicate that alcohol affords

temporary relief from the pain of loneliness, self-doubt, and fears. This observation is congruent with the observation that socialization can be effective in treating alcoholism.

Twenty-five percent of all prescription drugs are consumed by the aging. Many of the drugs are known to interact adversely with alcohol.

Alcohol consumption as well as the aging process decreases sensory and motor functions. This leads to a higher probability of accidents, and thus a greater utilization of health care resources.

Alcohol abuse also interferes with proper nutrition. This problem is especially serious for the lower-income aging whose nutrititional status may already be marginal. Not only does alcohol disrupt the appetite, but the redistribution of the food budget to cover the cost of drinking frequently results in reduced or less nutritious food consumption.

Estimates of the number of seniors with alcohol problems vary. In a Veterans' Administration review, 13 percent of those surveyed were alcoholics. Other broad studies place the total at between 5 and 8 percent, while specific studies of captive populations place the total much higher. Reviews of hospital occupancy conclude that at least 20-25 percent of all hospital beds are occupied by people with medical problems related to alcohol abuse. Persons aged 65 and over accounted for over one-quarter of all discharges and over one-third of patient days of care in all non-Federal short-stay hospitals. Almost 9 percent of those aged 64 and over who used psychiatric facilities were diagnosed with alcohol disorders. The percentage of alcoholics aged 64 or over in VA hospitals is estimated to be 16 percent.

The consensus seems to indicate alcoholism is a particular problem for the elderly. While the full depth of that problem has yet to be determined, an estimate that 10 percent of the elderly have alcohol problems appears conservative. Widowers over the age of 75 have the highest rate of alcoholism of any group in the country. The prevalence of this problem is compounded by the fact that physiological changes connected with age result both in a lowered tolerance for alcohol and an increase in its toxic effects.

III. TREATMENT

Until the 1950's treatment for alcoholism was more likely to have been incarceration or custodial care in State mental hospitals than medical or psychological therapy. Since that time, with the determination that alcoholism is a disease, a number of treatment modalities have developed. These treatment alternatives are outlined below:

1. *Alcoholism Specific Approaches:*

(a) *Alcoholics Anonymous:* This is a self-help program; a fellowship of men and women who have "recovered" from their own disease and who maintain their sobriety by sharing their experiences, strengths and hopes with others to help them attain and maintain sobriety. It is by far the most effective of all programs but, especially with the late-onset group of elderly alcoholics, does not meet all of the patient's needs, and, in some cases, actively estranges some who must find help elsewhere.

(b) *Aversion Therapy:*

(1) Antabuse (Disulfiram)—This is a drug which produces very unpleasant and sometimes dangerous symptoms if taken when alcohol is consumed. It can only be administered with the informed knowledge and consent of the patient—these can never be presumed.

(2) Hypnoversion—An attempt through autosuggestion hypnosis to induce an aversion to alcohol.

(3) Medical Aversion—The use of various emetic drugs to produce a conditioned reflex of Pavlovian nature.

2. *Multidisciplinary Approaches:* These include both socialization and medical models largely derived from the original recommendations of Nelson Bradley, M.D. These comprise the majority of in-patient treatment models. They use multidisciplinary teams involving medical care, psychiatric, psychological, social service, environmental manipulation and, where indicated, specific medications. They are an attempt to treat the "whole patient" but are basically alcoholism and not gerontologic oriented.

3. *Socio-psychiatric Approaches:* These are largely directed toward stresses of aging, based in geriatric services and applied in particular to socio-economically disadvantaged.

4. *Behavior Modification:* Based on recognition of the learning process and the role it plays in the development of behavior and attitudes towards it, it attempts to

replace undesirable behavior with desirable behavior through stimulus change and intervention.

5. *Group Therapy:* This has long been accepted as the most effective method for treating alcoholics. It involves getting in touch with feelings and emotions and acceptance of self and others. It is frequently reality-based and involves confrontation with sensitivity. It requires well-trained group facilitators and utilizes peer feedback and support.

6. *Individual Counseling.* This is most effective when used in conjunction with other forms of therapy. It is rarely effective when used alone.

7. *Family Therapy:* One of the newer approaches to emerge is the involvement of family members in the therapeutic process which helps to readjust interpersonal relationships within the family unit.

In general, it appears all of these methods of treatment are effective, though no one method has proven completely satisfactory. In all cases, regardless of the methodology employed, the OTA estimates the cost of not providing care exceeds the cost of treatment.

With that fact established, the central policy question remaining seems to be not whether reimbursement for the treatment of alcoholism should be provided, but whether current reimbursement policy supports the provision of the most cost-effective treatments. Available evidence seems to indicate this is not the case. The medically based inpatient rehabilitation services recognized by Medicare and other Federal programs are the most expensive treatment alternatives. There is no evidence to suggest they are any more effective than primarily nonmedical inpatient models or outpatient treatment.

IV. RESOURCES AVAILABLE TO COMBAT ALCOHOLISM

Public acceptance of alcoholism as a treatable disease has brought about rapid growth in the number of public and private treatment agencies over the last decade. These dramatic changes in attitude started to come about following the official recognition of alcoholism as a disease by both the World Health Organization and the American Medical Association in the mid-1950's. But it was not until the mid-1960's that changes began to take place in society's view and in the treatment of alcoholism. These changes came about as a result of three important court decisions which supported the concept that alcoholism was a disease and not a crime; the recommendations of governmental and private commissions which found that alcoholism should be a health issue not handled by the criminal justice system; and finally legislative reform. Legislative reforms have included decriminalization of public intoxication in 34 States, and the creation of a variety of public programs to help the alcoholic and his or her family throughout the nation.

In all there are now eleven Federal departments, and nearly 30 indivfdual agencies and independent governmental organizations that are involved in activities related to alcoholism and alcohol-related problems. These include the Departments of Health and Human Services, Agriculture, Commerce, Defense, Housing and Urban Development, Interior, Justice and State. Services and programs sponsored range from direct treatment services to training, education and research.

NIAAA

The first Federal law concerning alcoholism was passed in 1968. The "Alcoholic Rehabilitation Act, Public Law 90-574, embraced the concept that health care services should be provided to the alcoholic, rather than punitive measures. In 1970 this initiative was greatly expanded in the enactment of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Public Law 91-616. This major legislative initiative established for the first time a discretionary public health program to assist States, local governments and communities to identify and address the needs of alcoholics. It included the establishment of the National Institute on Alcoholism (NIAAA), and a modest program of treatment services demonstration, prevention and research efforts on alcoholism.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA), one of three institutes within the Alcohol, Drug Abuse and Mental Health Administration, has experienced large recent cutbacks. The Omnibus Budget Reconciliation Act of 1981 and subsequent continuing resolutions have cut NIAAA's budget in half and reduced its personnel from 191 to 116. As with ADAMHA, the services administration of the institute has virtually been phased out, with only research and a small investment in clinical training surviving. The National Center of Alcohol Education and the National Clearinghouse of Alcohol Information, two repositories for the dissemination of information, have also been eliminated.

Treatment

The Federal Government has a substantial stake in the funding of alcoholism treatment services. An estimated two-thirds of the direct costs of alcoholism treatment programs are paid for through Federal, State, and local government programs.

Federal programs include employee-benefit insurance packages such as the Federal Employees Health Benefit Plans; services provided by the Armed Forces and Veterans' Administration (VA) hospitals, including the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and until recently, progams funded by the National Institute on Alcohol Abuse and Alcoholism (NIAA) (now incorporated in block grants to States). In addition, and most important for present considerations, the Medicare program pays substantial amounts for the treatment of alcoholism.

In fiscal year 1982, Medicare paid an estimated $150 million to treat alcoholism and alcohol-based disorders. Extrapolating from comparable figures for 1979 suggests that approximately 90 percent of this total was spent for institutional care alone; the remainder was paid to physicians for their services.

Medicare

Medicare is a nationwide, federally administered health insurance program authorized in 1965 to cover the costs of hospitalization, medical care, and some related services for eligible persons over age 65. Since its inception, Medicare has not specifically provided benefits for the treatment of alcoholism. Rather, under the hospital insurance component of Medicare (Part A) alcoholism is treated as a psychiatric disorder under the general category of psychiatric health services; its hospitalization benefit for a psychiatric disorder in a psychiatric hospital is limited to 190 days per lifetime. For treatment of alcoholism in the psychiatric ward of a general hospital, on the other hand, the standard (physical illness) Part A Medicare reimbursement and coverage provisions apply; 90 days of hospital care in each benefit period with $304 deductible, and 25-percent copayment after 60 days, as well as a lifetime reserve of 60 days with a 50-percent copayment. According to NIAAA, the original limitation on psychiatric care was to avoid Medicare's reimbursing "custodial care," since Medicare was intended only to insure against illness that were being actively treated.

The supplementary medical insurance component of Medicare (Part B) provides partial coverage for outpatient psychiatric services. The formula is complicated, but it results in a 50-percent coinsurance benefit with a maximun reimbursement of $250 per year. For physical illness, however. Medicare pays 80 percent of a physician's reasonable charge after $75 deductible. Although outpatient psychiatric services are limited to a maximum reimbursement of $250 a year, there is no limit on reimbursement for physicians' services for medical or psychiatric care while a patient is in a psychiatric ward of a general hospital. The original limit on coverage of outpatient care was consistent with such limits by private insurers.

The Medicare program essentially funds providers who are physicians or are under the direct supervision of a physician performing services incident to those of a physician. This has meant that many non-acute care facilities and treatment centers that offer non-physician-based care have not been eligible for reimbursement under the generic statutes of the Medicare program. Until recently, many such programs were funded directly by NIAAA.

Medicaid

The Medicaid program provides medical assistance to low-income individuals and families. Treatment costs are shared by the States and the Federal Government. Each participating State (all States except Arizona) must provide certain basic health services, according to Medicaid regulations. States, however, have substantial leeway concerning specific coverage and interpretation of regulations.

According to NIAAA, a major limitation in the Medicaid program (by statute) is the exclusion of Federal financial participation for care in psychiatric institutions for persons between the ages of 22 and 64. With respect to other treatment settings, Medicaid may theoretically provide more options for treatment, although Medicaid statutes do not specifically mention alcoholism treatment. For example, States have considerable latitude in defining physician participation. Services need not be those incident to a physician's, and clinics may be reimbursed for the services of paraprofessional rehabilitation counselors.

In 1978, Medicaid provided 6 percent ($5 million) of the total receipts of NIAAA-funded alcoholism treatment centers. Information concerning how much Medicaid provided to other alcoholism treatment services is not readily available. In one study, the investigators found that 4 of the 45 State plans they reviewed referred

specifically to treatment for alcoholism; 2 of the 4 allowed coverage, 1 explicitly excluded coverage, and 1 limited coverage to detoxification. Eight other states were found to have plans providing a relatively favorable environment for inpatient alcoholism treatment coverage, and 23 States were found to have plans providing a relatively favorable environment for outpatient services. Annual levels of reimbursement for alcoholism treatment, when reported, were generally low (e.g., in 1978: $45,000 in Mississippi, $800,000 in Maine, $1,400,000 in Washington), except in New York ($32.1 million). A survey conducted by NIAAA in 1976 indicated that all State Medicaid agencies reimbursed for inpatient care of organic illness related to alcoholism, and a majority reimbursed for outpatient care for such illnesses. However, a substantially lower portion of State Medicaid agencies reimbursed for the treatment of alcoholism itself, especially when that treatment was not in a medical setting.

State activity

According to the National Drug and Alcoholism Treatment Utilization Survey (NDATUS), State governments provided $206 million in tax-derived funds to alcoholism treatment centers in 1980, or 21.9 percent of the total funds. Local governments contributed $97 million, or 10.3 percent of the total. Although the States constitute the largest single source of funding for alcoholism services, they typically do not operate treatment programs directly. The States' role consists of allocating resources from various funding sources to local programs. In addition, some States (e.g., California) have developed statewide alcoholism health insurance programs for their employees. Increasingly, State legislatures are considering mandating, or requiring, as an option, insurance coverage for alcoholism treatment. By September 30, 1981, such legislation had been enacted in 33 States, had been defeated in 14, was being considered in 2, and had not been considered in only 1 State.

Because of changes in Federal grants, States have more latitude in deciding how Federal funds are spent; at the same time, they have fewer funds. In fiscal year 1983, 35 percent of the sub-block grant for alcoholism, drug abuse, and mental health had to be allocated to alcoholism; in 1983 and 1984, funds may be transferred by the States from alcohol and drug abuse, to mental health. In fiscal year 1981, block grant allocations for alcohol, drug abuse, and mental health services were found to be 20 percent lower than the levels of predecessor categorical programs; in the first 6 months of the new block grant program, 15 percent of alcoholism, drug abuse, and mental health grants had been drawn by the States.

V. ADEQUACY OF CURRENT RESOURCES

There are two fundamental limitations to the existing alcohol treatment programs. First, regardless of the treatment method, only negligible efforts are directed at outreach programs designed to identify the untreated alcoholic. The combination of this minimal outreach effort and the general tendency from denial associated alcoholism, provides a high probability the aging alcoholic will go untreated.

The Office of Technology Assessment estimates the yearly cost of each alcoholic to be in excess of $10,000. If only, a portion of the sum could be recovered by a moderately effective treatment system, significant reductions in the economic, social and health care costs of alcohol abuse would be possible.

Second, for those identified as alcoholics, professional treatment efforts are defeated by restrictive reimbursement policies and regulations. To the extent public resources are directed at the problem, their emphasis is on the most costly treatment alternatives. Professional activities associated with the essential "continuum of care" or after care are not reimbursed under existing regulations. In fact, there is evidence to suggest many alcoholics are treated as inpatients simply because outpatient care is not available under government programs.

A Department of Health and Human Services audit concluded in September of 1982 documented this problem. The DHHS audit reviewed alcohol treatment facilities operating in three States. The audit concluded 75 percent of the hospital days said to be associated with the alcohol treatment were inappropriate. Medicare payments for these inappropriate charges totaled $325,000.

In addition, the audit identified:

1. Patients who were moved from one facility to another in order to escape local limits on treatment and continue Medicare funding. In one case a 66 year old Medicare patient was put on a champagne flight to Las Vegas for treatment at a Nevada hospital after he had used up the treatment allotment in the California branch of the alcohol treatment chain.

2. Quota systems employed to encourage hospital admissions by the counselors;

3. Poor care and inadequate general health services resulting from attempting to qualify alcohol treatment centers as acute hospitals for reimbursement purposes. In

28-356 O - 84 - 3

one case, a woman weighing 64 pounds was admitted to an alcohol unit and observed for two days before being transferred to another facility where she died 10 days later. She had been suffering from malnutrition.

The audit also questioned the repeated hospitalization and treatment of some patients. Auditors identified one individual who received treatment at public expense more then 50 times. There was no record of attempted follow-up or after care between the periods of hospitalization.

VI. CONCLUSION

The development of the current system for treating alcoholics and alcohol abusers has been closely tied to funding and reimbursement policies of both private and governmental insurance programs. Since the acceptance of alcoholism as a disease over 25 years ago, an elaborate medically based treatment system for alcoholism has evolved. In some cases, development of treatment services has preceded reimbursement policy; in other cases, however, treatment seems to have developed around what is reimbursable.

In recent years, a number of private insurance companies, employers, and the Federal Government have expanded benefits for alcoholism treatment. Reimbursement for acute medical care as well as inpatient treatment for alcoholism is currently available, although coverage is not universal. Non-hospital-based treatments, including outpatient care, aftercare, and non-medically-oriented residential care, are less frequently reimbursed, although there is a trend toward developing such benefits. Thirty-three States currently mandate some form of coverage by health insurers for alcoholism treatments.

Recent emphasis on expanding insurance benefits for alcoholism treatment stems from a belief that the costs of not providing alcoholism treatment are greater than the costs of providing such treatment. Whether alcoholism treatment should be reimbursed at all, therefore, does not seem to be at issue. The essential question at this point seems to be whether current reimbursement policy supports the provision of the most cost-effective treatments. Cost analyses indicate the beneficial effects of alcoholism treatment, yet questions remain as to whether ineffective treatments are being employed and concerns about whether lower cost treatment alternatives (such as nonhospital care) are available to treat alcoholics but are not being used.

The nation's health care budget has expanded to almost 10 percent of the gross national product, and although efforts have been made to improve benefits for alcoholism treatment, increasing such benefits conflicts with needs to reduce health care expenditures. There is an obvious need to develop a more efficient alcoholism treatment system. With such a system, it is less likely that services will be denied to a large number of people or that costs will be prohibitive.

Ms. FERRARO. Our first witness to open the hearing this morning is one of the country's most distinguished actors, Jason Robards.

Mr. Robards, if I could just take 1 minute. I know as is evidenced by the applause that this audience gave you when you came in, that the audience knows you. But I did want to just say one thing, that perhaps they did not know, and that is that in 1972 Jason Robards was almost killed in an automobile accident. Had he died, this Nation would have had a tremendous loss of one of the greatest contributors to our culture.

In 1977, Jason Robards won an award for "All the President's Men." And do you remember that movie? How wonderful he was. In 1978 for "Julia," another academy award, an oscar.

I just flew back from Florida. I did a speech down there and the film on the plane was "Max Dugan Returns" and you were dynamite. Currently he is on the Broadway stage appearing right now in marvelous revival of "You Can't Take It With You," which I am going to go see.

I cannot tell you how pleased I am that you are with us this morning. The posters around the room indicate how terribly involved Jason Robards has become with the National Commission

on Alcoholism and what a vital spokesman he is for it. I welcome you and I welcome your testimony. Thank you.

STATEMENT OF JASON ROBARDS

Mr. ROBARDS. Thank you, Congresswoman Ferraro and Senator Pepper and Congressman Biaggi, for having me here today to address this very important issue which affects, as we know, many more millions than the statistics give us.

If I may please read a statement, and then I would appreciate it if you would ask me anything.

Ms. FERRARO. Proceed.

Mr. ROBARDS. Mr. Chairman and members of the committee, all of you are aware, and fortunately I am, too, that I was invited here this morning because I am an alcoholic. Recognition of this status was probably a more dramatic event than any drama I have ever played.

The number of alcoholics in America today is estimated to be 5 to 15 million. I quarrel with that. We have a population of close to 250 million and I would say that unbeknownst to a lot of us, it would be close to 100 million whose lives are directly affected by alcohol, not through side effects which families suffer.

Thirty to fifty percent of all hospital admissions are alcohol related. And it is a particular problem in the elderly. We have loneliness and retirement. We have what to do with ourselves and it is party time and we are retired and before we know it, the system is not able to handle even physiologically the breakdown of even a very minor consumption of alcohol.

Thirty-two million people will be over 65 by the year 2000, and 4½ to 5 million will be alcoholics. We know the implications of alcohol on the automobile disasters. Most of these figures you are aware of because they are statistics which I read on your fact sheet. I am one of your statistics.

I have found that making a public, personal statement about my affliction with the disease of alcoholism has helped many people, friends and strangers alike, to take a closer look at themselves in relationship to this disease, and many of them seek help. It has given me the greatest feeling of accomplisbment that I have had in my life. I feel that this accomplisment is more than any I have made.

An alcoholic is defined, in its most simplest terms, as a person who drinks or who has problems with drinking, and in spite of it, continues to drink.

I started drinking in the Navy. This is not to run down the Navy, because it is sort of a way of life there. But, because I was young at that time and it was not readily available at sea, I did not think I had a problem. It did not affect my work or behavior. In fact, after the service and while a struggling actor in New York, my first wife and I could only afford a bottle a year that we put in the Christmas punch. During the year, it was an occasional beer.

With success, success is a big thing that enters here, when "The Iceman Cometh," I drank more. But as far as I was concerned, I had no problems There was much evidence to support the fact that I did indeed have a problem, faithlessness, divorce, then remar-

riage, then divorce again, a sole interest in work to the exclusion of all else but drinking. I chose to ignore all of this and rationalize it as part of my profession and the ever-ambitious climb upward. In retrospect, it is now easy to see, I had the disease. Unfortunately, you do not wake up in the morning with red spots or something. You wake up and you need a drink.

And this is an important point. Work is the last thing to go in the alcoholic's descent. Work is our last vestige of self-esteem. We never stop to see signs along the way that are pointing to the end of our work, and, hence, our road.

My road ended in 1977 in a drunken, gruesome, single car accident. It was fortunate there was nobody else around and I did not do other damage. I crashed my car into a mountainside, less than 1 mile from home. This was no accident. I was traveling this road from a beginning: a broken home, an alcoholic father, despite success very low self-esteem, a denial of my gifts, a denial of my drinking problem, more broken homes of my own doing, a denial of a new and wonderful home, wife and child, and finally a denial of my own life because all vital functions had stopped after the accident.

Miraculously, I was pumped back to life and the pieces reassembled, and yet, after my recovery, I started drinking again and did not stop until 1 year later when I stopped denying I had a drinking problem. My new play, my work, was going, my wife and child were going, and I knew that I was going. This time it was for good.

I stopped because of love, the love of my wife and child, and somewhere inside me a tiny bit of love for myself that said, "You really can be that nice guy you were when you were a kid." That was 9 years ago.

Self-esteem began to return and my shyness began to leave. I began a second life, first in living, second in working. But the foundations of love and care were the basis of this new life. The success and recognition of my work were, and are, secondary.

I say all this because I would like some answers. How can we help 10 to 15 million people? As I said before, I quarrel with this figure; I think it is much more. It seems clear to me that an early education in the causes and symptoms of the disease is essential. Although I had lived with an alcoholic, I had never really looked upon my father as such. He may have been short on rent and food at times, but he was always there, he was mine, and I loved him. His career as an actor had careened to a halt because of drink and he died relatively young after giving up the booze, too late to have the health and the youth to work.

The stigma of the disease, the perception as a lack of self-control and self-indulgence or moral bankruptcy, is slowly fading, but it still definitely remains. Alcoholism is a progressive disease, it slowly destroys. The ability to function lingers for a long time; all the while the impairment is building, whether it be the heart, the liver, emotional stress or motor reflexes. All are getting set for a massive malfunction unless intervention takes place.

More treatment clinics or centers, easier access for families and principals to them, the nonhospitalized approach in cases not at crisis levels and intense followup programs, whatever is effective for each individual and circumstance. It is important that we begin

to recognize and develop programs to arrest and prevent this disease. Physicians need to recognize this, too.

I have been working with the Mayo Clinic and we go to doctors around the country and give them a program on alcoholism. Many doctors prescribe drugs to people for sinus for various congestive ailments. You can tell, doctors have told me, by the weight of the patient file and how many visits they have had, that alcohol has been involved. It is evident just by the weight of the person's personal medical file.

Physicians need to recognize their responsibility in candidly telling their patients that weight loss and blood pressure, stress, or whatever is caused or complicated by excessive drinking, which can cause alcoholism.

I have one last thing that I must say. I do not want to bite the hand that feeds me, sometimes feeds me, television. But I am very, very upset about the television commercials glorifying the macho image of chugalugging beer in a senseless invitation for young people to drink. I know my 8-year-old son, if we see a football game, we watch television very infrequently but we see these sports heros doing these things, he wants a six-pack of apple juice to belt down. This is a beginning in a way when we permeate our young with this. Every kid wants to emulate his hero and that includes drinking.

My gratitude to the committee for your efforts and for allowing me to come here and remember. I must say that any help costs less than no help. Thank you very much.

Ms. FERRARO. I want to thank you for your very moving testimony, Mr. Robards. Let me just make an additional comment regarding the media and their approach with commercials to the problem of alcoholism.

The one thing I am always pleased to see, as a mother of teenage children, is the commercial, and I guess it is put on by the National Commission on Alcoholism which shows that there is a real possibility that there can be problem drinkers who are teenagers. You know the commercial where the problem drinker is a child, a young child.

Mr. ROBARDS. I am not a television viewer.

Ms. FERRARO. It is a marvelous commercial that focuses in on the fact that there may be people drinking who we do not know about, whether they are teenagers or they are elderly. That this is a problem that does not manifest itself sometimes on a daily basis for us to be aware of, but which is occurring throughout our society.

One of the things that you said that I thought was very interesting, was that work is a last vestige of self-esteem, and to many alcoholics low self-esteem is part of the whole syndrome.

Today's recession has pushed a lot of people out of work. Today's recession has forced a lot of people into early retirement. The recent budget cuts have given a lot less people the ability to function within our society with a feeling of pride.

What is your view on what could be the long-term effects, especially with reference to the elderly?

Mr. ROBARDS. You mean about losing self-esteem? What one does is try to blank out, as you say, early retirement, loss of jobs. I know in my own case anytime I would use alcohol not to get drunk par-

ticularly, but to not face the problems that I had. And I felt that as long as I was in that sort of fog, I did not have to face it. And it is a trap into alcohol, into the disease itself. I think it is almost a formula that it would increase the rate of alcoholism in this kind of situation. You have to feel self-worth.

You know, all of us, no matter how healthy our egos, have our various stages of life. We have these moments of, gee, I wonder if my self-esteem drops a bit. I think if it is taken away from you by lack of work, lack of where you are going, you will go into some form of trying to forget it, with drugs, or alcohol, or Valium.

Ms. FERRARO. You said another thing I thought was extremely interesting. You said, "I drank on several occasions. I drank but I had no problem." The accident obviously was what brought you face to face with the problem. What about those people who are going through life also elderly, saying to themselves, "I drink but I have no problem." How do we get them to recognize that they have a disease? How do we get them to get help?

Mr. ROBARDS. Confrontation is one of the hardest things to do. I have had friends that I have tried to help or say something to, and they resent it terrifically. In fact, one of my best friends, who is now not drinking anymore, did not speak to me for 2 years because I confronted him.

But the only thing you can do is take those insults or whatever they throw at you. If you care enough about another person, you have to keep confronting them. And if enough people do, they will finally say, "Maybe somebody out there was right, maybe I do have a problem."

I hate to have it come to the point where everybody will say, "Well, let them hit the bottom and that is the end." They then will either die or they will pick themselves up and go on. You hate to see that happen. That is probably one reason why I am here expressing this, to have people do some self-examining.

Ms. FERRARO. I certainly want to thank you for your testimony.

Mr. PEPPER. Mr. Robards, there should be some kind of a medal, some sort of a national reward, for such courage as you have exhibited in doing what you have.

It is even more difficult sometimes than running across an open space when they are shooting at you.

There are two things that you mentioned. One is our committee has done what it could to remove age as the basis for mandatory retirement of people from their work because as you indicated, loneliness and idleness tend to encourage drinking, or something like that.

Our legislation adopted in 1978 provides that if you work for the Federal Government, you cannot be forced to quit, even if you are as old as Methuselah as long as you are doing your job. No age is the criteria. The same thing is true with people out of Federal work in general, with a few exceptions, they cannot be made to quit below 70. We are trying now to lift that 70 so that age will be no more a criteria in employment than sexism or racism is a criteria in employment. We feel if we can keep people busy doing something, having meaningful employment, that tends to occupy their time, and maybe have them get away from idleness.

The next thing after the idleness is the loneliness. So many people become lonely when they get old. Maybe, as I have, they have lost their lovely spouse. And I know my work is my satisfaction; it keeps me from unhappy memories. You experience the same thing.

So, we need programs to bring people together. I hope some time that we can have young people who will organize some sort of an organization so that young people would go visit older and be with them. Giving them the comfort of their company, like the Big Brother organizations, where older people work with the young. It would keep them employed.

Do you feel that keeping people employed and busy with their activities and bringing them into association with others to get rid of loneliness and the like, will help them to avoid alcoholism?

Mr. ROBARDS. I think it is vital. I think we are a country that is based on the work ethic and to suddenly remove it, along with loved ones that may be gone, leave a tremendous void. We have to keep them working, creating, writing, painting, whatever, being together. I feel it is vitally important that we do this. I think it is marvelous that we can go and keep active with our friends as long as our life lasts.

Mr. PEPPER. One other thing, we all respect the importance and the rights of the media, printed and electronic, but we, I am sure, do feel reluctant to allow anybody to profit by tempting other people to do things that may be to their death or their ruin.

Mr. ROBARDS. That is a big responsibility for advertisers and companies to have those policies. How we beat that I do not know? The greed is incredible.

Mr. BIAGGI. Will the Senator yield?

Mr. PEPPER. Yes.

Mr. BIAGGI. On that point. I thank the Senator for yielding. The chairman raised that question and you made reference to the beer commercials when young folks are looking at this macho image, football and the like. We, in the Congress, have banned commercials for tobacco, for cigarette smoking, and sale of cigarettes. Are you suggesting that we should apply that ban to beer, and alcohol, and wine? Are you suggesting that we go further? We banned cigarette commercials on TV. It certainly sets up a state of mind, as to the acceptability of alcohol to young folks. It becomes a fashionable way to go.

Mr. ROBARDS. I would not mind seeing that happen, I must say. It is out there and available and there are other ways to advertise it, except through the medium that reaches so many. People do not read anymore in this country. Two percent of the people buy books; so this is a gigantic intoxicant in itself, television. This is subliminal advertising. You know a kid goes out and plays a softball game in high school. They have a case of beer at first base; if you get a single, you get a drink. It is all related to accomplishment through sports. Sports are very important to us, as we know. They are tremendously important, as are studies; they round out the individual. I think to use it in this manner is dreadful. I would not mind seeing a ban.

Mr. BIAGGI. Thank you very much for your response. The argument that was offered when Congress contemplated banning ciga-

rettes is that it would affect the whole industry. Well, the fact remains it would affect the commercial industry, television, and media. The fact remains notwithstanding the banning, the cigarettes have increased in sales.

Mr. ROBARDS. True. Prohibition, that old bugaboo again.

Mr. PEPPER. Mr. Robards, I just want to add to what Ms. Ferraro said, our profound gratitude to you for your coming. And on behalf of a grateful America I thank you for what you are doing.

Mr. ROBARDS. Thank you.

Ms. FERRARO. I must say, the news of this hearing really traveled fast, as well as the comments being heard here today, because evidently your story of "The Bishop and the Congressman" has evidently reached the Diocese of Brooklyn faster than the speed of light, because Bishop Sullivan is here. He just went out to see Jason Robards. We are going to invite him to join us at the table. Bishop Sullivan has evidently heard the story and a Sullivan is not going to let either a Ferraro or Biaggi get a better room up there. He will be coming in in just a minute and he is going to join us. He is the head of Catholic Charities for the Diocese of Brooklyn, which is the sponsor of this center.

Bishop, I invite you to say a few words to the hearing, and we will proceed with the next witness.

STATEMENT OF BISHOP SULLIVAN, HEAD, CATHOLIC CHARITIES FOR THE DIOCESE OF BROOKLYN

Bishop SULLIVAN. I just want to say how much we appreciate the three distinguished representatives of the people coming to this community, where we have had some excellent representation, not only by Geraldine, but by Dennis Butler. The people of this center, in many ways, to us, represents a community of hard working people, who all their lives supported this great country and this great city; they have come together. We have built, a few blocks from here, a senior-citizen-housing development that has served the people of this community. And this center every day functions as a great opportunity for an extended family to come together.

They are people who are not only interested in their own, what is good for them, and how they advance their own interests, but most importantly for all the other people. If you go up to this housing development they say:

> We were fortunate to get in. We know there are so many other people who have the same rights, the same needs, and yet there is not anywhere near sufficient housing.

I can only say to the people here that we have four committed senior citizen housing projects, three of which will be done this summer. And it is our hope that in some way we can respect the dignity of the people who have made such a contribution, given such an image, and such an important kind of model for what the rest of us should become by the way they live their lives in this community.

We are delighted that the representatives have shown you such respect by holding this hearing today in your presence. Thank you.

Ms. FERRARO. I want to introduce to you your assemblyman and your soon-to-be State senator, George Amarato.

I would ask our next witness to come to the table, and while she is doing that, I will switch mikes so we do not have to hold this one. Helen Hernandez is director of public affairs for Embassy Communications, producers of "Archie Bunker's Place."

Ms. HERNANDEZ. Thank you.

Ms. FERRARO. I am delighted, Ms. Hernandez, that you have joined us. As many of you know, the opening scenes of the popular television show, "All in the Family" and "Archie Bunker's Place" are filmed right here in the Ninth Congressional District. Therefore, it is only fitting that this hearing today will feature film clips from recent episodes of "Archie Bunker's Place" dealing with the problem of alcoholism.

I am delighted that Helen Hernandez, director of public affairs for Embassy Tandem Communications is here today. Embassy has consistently been a leader in bringing important social issues into the living rooms of millions of Americans.

It is vitally important that this type of programing continue, and I commend Embassy Communications for their excellence.

I have to tell you on a personal note that I was rather distressed to hear that I am losing one of my favorite constituents. As Archie's Representative in the U.S. House of Representatives, I have to say that I was disappointed that CBS has announced plans to cancel "Archie's Place."

In 13 years Archie has become so much a part of our culture, that the chair that he always was yelling at Edith to get out of, is in the Smithsonian. So now we have a national figure right out of the Ninth Congressional District. I welcome you and I welcome your testimony, Ms. Hernandez.

STATEMENT OF HELEN HERNANDEZ, DIRECTOR, PUBLIC AFFAIRS FOR EMBASSY TANDEM COMMUNICATIONS

Ms. HERNANDEZ. Thank you. Before I start, on behalf of our company, we certainly would like to thank you for the statement you made on behalf of "Archie Bunker's Place" into the Congressional Record on May 18. Thank you again.

Good morning, Chairman Pepper, and honorable members of this committee, and Your Excellency Bishop Sullivan. My name is Helen Hernandez and I am the director of public affairs for Embassy Tandem. Tandem was founded by Norman Lear, who has built his reputation on weaving difficult social issues and real-life drama into entertainment programing.

Norman has a deep awareness of the power of the medium of television to affect public consciousness and major social problems and to prompt viewers into action. With "All in the Family" and its successor, "Archie Bunker's Place," Embassy Tandem largely pioneered this method of making commentaries on our troubled times in the context of an entertainment program intended to amuse, sadden, and provoke the audience.

You may recall episodes where Edith Bunker weathered the difficult transition of menopause, where Michael Stivic stood up in opposition to war, where Archie tried to cope with the fact that the new woman in his life was Puerto Rican.

28-356 O - 84 - 4

Embassy Tandem has these programs in comedy and drama formats to confront many tough issues head on, such as child molestation in "Different Strokes," an episode which has received commendations from Members of Congress, the State of California, Los Angeles County, the city of Los Angeles, and Parents United, a self-help organization for victims of child sexual abuse.

At your invitation, we have come to Queens, Archie Bunker's home, to share with you two episodes of "Archie Bunker's Place" which dealt with the societal plague of alcoholism, the pain of recognizing that one has a drinking problem, the agony of admitting it, and the force of will required to seek help.

In the first of these episodes aired during the second season of "Archie Bunker's Place," one of Archie's employees, Veronica Rooney, played by Anne Meara, is found sleeping off a binge in the kitchen of Archie's tavern. Veronica seeks help, but falls victim to the alcohol and pills syndrome. Ultimately, with Archie's help, Veronica tearfully faces up to her dependence on alcohol.

Ms. FERRARO. If you just turn and look at the monitors you will be able to look at the show.

[Video tape shown.]

Ms. HERNANDEZ. In the second episode, aired a year later, Veronica has a short reunion with her estranged husband, Carmine, played by Jerry Stiller. She faces one of the toughest decisions of her new life as a recovering alcoholic, whether to give into his pressure to join him for just one drink.

[Video tape shown.]

Ms. HERNANDEZ. As a point of information, you may be interested in knowing that these cassettes are available on loan, free of charge, to any organization or school that wishes to use them.

Mr. Chairman, we have received frequent requests for copies of these episodes. In their own small way, they drive home a point that has been echoed many times since Ray Milland survived his lost weekend, that alcoholism is a human drama requiring caring, understanding, and guts to make it through.

In your request for us to appear, you indicated your interest in the future of "Archie Bunker's Place." As it happens, the CBS television network has canceled the series and it will not return in the fall. CBS has indicated that it will not return partially because of its demographics.

You may be interested in knowing that 40 percent of the viewing audience of "Archie Bunker's Place" were 55 or over, and that it was one of the most popular comedies for this age group on prime time television. Yet, the network felt that programing in this time slot should be directed to a much younger audience.

This brings to mind an important problem. The ability of concerned members of the creative community to share their visions, their lessons, their perspectives on social problems with the viewing public, which needs to hear about more than the misadventures of three wild and crazy kids who live in a beach house in southern California, or yet another violent cops and robbers show.

Mr. Chairman, the three networks ultimately decide which shows will and will not reach American viewers, which ideas will and will not cross the public airways into tens of millions of homes.

Under current FCC regulations, we as producers of "Archie Bunker's Place" and other series retain substantial financial and creative control of our program. It is this relative independence provided by something called financial interest and syndication rules that has provided producers like Embassy Tandem the wherewithal to stand up for our decisions on which hard issues to tackle. We have often confronted network intransigence on script ideas which might make the viewer uneasy. These rules contribute markedly to television's reality quotient.

The FCC threatens to abolish the rules. Legislation introduced by Mr. Waxman and Mr. Wirth, with 100 cosponsors would prohibit FCC action to repeal for 5 years. If you agree with us that television, which provokes and educates, which brings important treatments of compelling social issues such as alcoholism into millions of homes, which enhances public understanding and sympathy is important, we hope you will join Mr. Waxman and his colleagues, in support of H.R. 2250.

Mr. Chairman, we at Embassy Tandem plan to continue tackling serious and controversial subjects in our comedic and dramatic productions. A small tavern in Queens, N.Y., may no longer provide the avenue for these real life dramas, but if programs such as the episodes of "Archie Bunker's Place" that we sampled today can continue to reach millions of viewers and elicit sympathy and concern on such important matters as alcoholism and society's treatment of the elderly, we will be proud of our small contribution. Thank you.

Ms. FERRARO. Thank you. I want to thank you, Ms. Hernandez, for your testimony and for sharing your tapes with us. I must say they are a very strong statement on the problem of alcoholism. Those tapes, as you saw, showed some of the things that Jason Robards was talking about. In the first one, the inability to confront one's self with the problem that one is an alcoholic. In the second tape confrontation with another individual and that individual not being willing to admit that he is an alcoholic. And the effect that alcoholism has on people's lives, their physical looks, and in addition to that, the job situation. I think that they are very strong statements, and I appreciate showing them here today.

We have all laughed about programs like "Archie Bunker's Place," because sometimes some of the things he does are outrageous. Some of the statements that were made on that program have not been dealt with on any other program. I am an Archie Bunker watcher. And I have seen some of the individual episodes that do deal with social problems and I feel they must be discussed openly in our society.

I am not yet a cosponsor of 2250. I have done quite a bit of research into it. I will probably go on it. I feel very strongly about the ability of independents to produce that type of program and again to allow the American public to have some sort of educational information at the same time they are enjoying the public way. So I thank you for your testimony.

Mr. PEPPER. I have no questions. I, like Geraldine Ferraro, and like a large part of the American population have been an Archie Bunker fan. And, frankly, I like the clever way many of these issues, controversial in nature, are assimilated into a program,

without diminishing the entertainment value. And the message is very subtly disseminated. And you serve a purpose.

Geraldine said she is going to sponsor that. I would just advise that I have sponsored it. In addition to that, there is a whole other ethnic dimension to be dealt with as far as that show is concerned.

Ms. HERNANDEZ. I might, if I could, add one more point. Since the issue was brought up about teenage drinking, you may be interested in knowing that our company has been working with Mothers Against Drunk Drivers in California. And because of our work with that, we produced last season two shows dealing with teenage drinking on "Facts of Life" and "Different Strokes."

Ms. FERRARO. Thank you very much.

Our next witnesses are a panel, Mr. George McNamara, if you would come to the table, of New York; Mr. John Reinhart; and Ms. Elizabeth Kiernan, who is a nurse, director of nursing at the Manhattan Bowery Corp. Mr. Sheehan, please come forward.

PANEL 1, CONSISTING OF GEORGE McNAMARA, NEW YORK; JOHN REINHART, NEW YORK; ELIZABETH KIERNAN, DIRECTOR OF NURSING AT THE MANHATTAN BOWERY CORP.; AND JEREMIAH SHEEHAN, NEW YORK

STATEMENT OF GEORGE McNAMARA

Mr. MCNAMARA. Good morning, Congresswoman Ferraro, Congressman Pepper, and Congressman Biaggi. My name is George McNamara. I am age 71. I will be 72 in November. I was born in the Bronx and lived in the Bronx all my life. And I am a recovering alcoholic. I prefer to use the expression recovering alcoholic for the fact that I believe there is no cure except the grave. But meanwhile, I know as long as I live, I have another chance of going out and getting drunk again; therefore I am very much interested in having facilities available where I could receive help if I needed it.

I know from my own predictions there are roughly about 10 million alcoholics in the United States, and that they need treatment. Unfortunately, from my own experience, I was retired from my job in 1972, and I turned to the only friend I had at that particular time, and that was brandy. By about 1974–75, I was in Veterans Hospital because I had been a soldier during the war. I was treated for what they call gastroenteritis because when they asked me if I drank, I said, "Yes, I drink occasionally." They said, "What is that?" I said, "About a pint of wine a week." At that stage in the game I was drinking about a fifth of brandy a day. Finally, in 1976, I went into the hospital again and they did not ask me anymore. They put me in the alcoholic ward and I was detoxed for 3 weeks.

When I came out of that, I became fairly interested in alcoholism, maybe wondering what happened to me. I picked up a book called "The Lonely Sickness." For the first time in my life I realized really that I had a sickness, and that the main aspect of it was loneliness. Reaching out for the alcohol was about the only means I had of coping with the situation.

By the time I finally put myself in for treatment, I was drinking a quart of brandy a day. I felt I could not live with it. I could not live without it and I did not know what was wrong with me. And

not knowing what was wrong with me, I did not know where to go. As far as I was concerned, there were no facilities at all.

I had two doctors between 1972 and 1976 who suggested I join AA. I could not even think of that because, after all, I was not a bum. I had worked all my life. I had a certain kind of respectful occupation. I was not living on the Bowery. That was my concept of what an alcoholic was, and I did nothing about my condition.

While I was in the Veterans Hospital, we were exposed to the thoughts of AA. Probably somewhere along the line, a bell rang for me, but the point was that I was convinced somewhere along the line that as an alcoholic I could not drink anymore. I did not like the idea, but I was obliged to cope with it whether I liked it or not.

As I became more interested in alcoholism, I started taking courses, and eventually, I was employed in the field and worked for 4 years in a detox center. I am currently not working, more or less by choice, and certain other circumstances, but I do expect to get back to work very shortly.

Again, I can only say that my chance at working at all, and perhaps working for the benefit of others, has been largely due to the fact that I have been in the process of recovering. It is a very necessary form of self-improvement, if you want to call it that. I receive a great deal of assistance from various sources. I am aware of the fact that a good deal of our tax income is derived from the product that is sold in bottles and so on. I can only recommend that it would be a good idea to trap off some of that income from the beverage industry to maintain agencies where persons who do not know either what is wrong with them, or will not admit what is wrong with them, or do not know what to do about it, will have access to facilities where they can be treated.

I am very sorry I did not type up a statement.

Ms. FERRARO. That is fine. We appreciate your statement. Thank you very much.

Mr. Reinhart.

STATEMENT OF JOHN REINHART

Mr. REINHART. Good morning, everyone. My name is John Reinhart. I am a grateful alcoholic. I want to thank you, Geraldine, Mr. Pepper and Mr. Biaggi, for inviting me to give me this opportunity to admit once more that I am an alcoholic, and to assure all alcoholics that help is available. It is a pleasure to see Bishop Sullivan and all of you other people.

I started my drinking at a very early age and I was damned with what is known as a low progression. My rate of progression was very, very low, or slow, if you will. It was not until I was in my upper 50's that alcohol started to take over.

At first I drank for pleasure, and then I started to drink. Well, I was a beer drinker for a long, long time. I found that the companionship of a bar in the evening when I was waiting to go to school was pleasurable. And as I worked myself up into the businessworld, I found that I was more in the upper echelon of the business people; I had the distinction of joining the three martini lunch bunch. I thought that was status and I thought that was wonderful, and I enjoyed it.

I switched to vodka because in my early days I had tasted scotch and it tasted like iodine. I tasted whiskey and it tasted like bad medicine. And I sort of took a liking to the dry vodka martini. I progressed at home because you cannot sit around the house drinking martinis all day on Saturday and Sunday, so I switched to Fresca and orange juice a year ago, and a lot of vodka. That became my favorite drink. I found I would always want a drink. I found not only would I have a drink for breakfast, but on my way to work I would stop off at a local gin mill and have one or two martinis to get me started.

I used to take it to work, too, because I was suffering from the DT's; I could not possibly hold that glass. I would stir it a few times and take a couple of quick sneaky sips before I could actually raise the glass to my mouth. That is how far gone I was. I knew that I was having trouble. I was making a fool of myself. At the vice president's housewarming party, I was one of the early birds to fall into the swimming pool. I had to be driven home.

Several months later at the president's daughter's wedding, again, I made a fool of myself. I was considered a Fred Astaire-Ray Bolger amateur and I got out on the dance floor with the mother of the bride; they had to remove me when I tried to dance with the father of the bride. He was my boss.

The following Monday morning, he called me into the office and I said, "Gee, Jim, I am sorry. I made a fool of myself." He shrugged it off and said, "Boys will be boys." But a few years later I knew and everybody else knew I knew that I was having a problem. Yet, I was ashamed or stubborn. As Mr. Robards mentioned before, if you are an alcoholic the word honesty takes on a different meaning, you can be dishonest with yourself, still a perfect citizen, never robbing any banks or doing any dastardly deeds, but if you are not honest with yourself and cannot admit that you have this problem of alcoholism, that it is crucial to your life, then you are a dead duck. As Mr. McNamara said, the end is the grave.

I think that the fact that this one morning, on the way to work when I hit my bottom, I left the gin mill after two or three, I do not know how many martinis. I was no longer drinking because I wanted to drink. I was no longer drinking because I enjoyed it. I had a compulsion. I drank because I had to drink. If it was not there, I had to go get it. But this morning when I left the gin mill, the buildings suddenly toppled, the sidewalks curled up and I rolled into the gutter. And there I was.

A good samaritan came along and got me a cab. I went home. My wife called the doctor. The doctor, a personal friend, came in, and he said, "John, I will have to send you to the hospital. You need detoxification." I said, "Please do not send me." He said, "We will try it for a day or two." He gave me a shot of something. He gave my wife a couple of Valium pills. And he warned me, one little beer, one little piece of alcohol, drink of alcohol, and you are a dead duck. For 3 days I sweated it out.

Big men came sneaking into the room with nails to dismember me. My lovable Labrador retriever came into the room blood and saliva dripping from his mouth. His eyes all glary. It was all in my mind.

Gradually after the third day I was able to negotiate a little. I called for help. And AA came along and I went to a meeting. That was my salvation. Once I admitted I was an alcoholic, it was a load off my back. And believe me, I know now, that that one drink is going to be the death of me. I look at that one drink as one part of a huge log pile that is holding back a river, and here I am in this placid pool of water behind that logjam.

I have sobriety. I have self-respect. I have love. I have life. I have living. I have everything. But once I pick up that one drink, it would be like removing a key log from that jam. When that key log goes, down goes the river and I go into the pits of despair, despondency, disgust, and death. I do not want to do that. Thank you.

Ms. FERRARO. Thank you. Mr. Sheehan.

STATEMENT OF JEREMIAH SHEEHAN

Mr. SHEEHAN. After listening to these two gentlemen, I can only reiterate what I have heard. I could go beyond that I am an alcoholic and have been since the end of World War II, although at that time I would not have considered myself an alcoholic. I did not realize there was such a thing. Excessive drinking, occasional drunks, I thought that was normal. It would progressively get worse. And I do not want to bore you with all that. I finally got around to doing something about it around 1974. Since then, I had only one occasion where I failed and that was for a very brief period of time. As I said, I do not want to give any details. They are not pretty.

I am more interested in the reason we are here, elderly alcoholics. As you get older, your body cannot handle alcohol anymore. It can be very life threatening to say the least. That is an understatement. I do not have any suggestions, I wish I did. But any help that can be given, I believe desperately should be given. Two-thirds of our elderly alcoholics are what I like to refer to as closet drinkers; they hide it. They are lonely anyway. The only time to go out is to do shopping. You know, things that have to be done.

It is a terrible situation. I do not know the solution. I wish I could come up with one. If there is a solution, I think it should be handled through you people.

Ms. FERRARO. Thank you very much, Mr. Sheehan.

If you have prepared testimony you would like to give us, we will make it part of the record. Thank you very much. We will make it part of the official record of this hearing.

[Prepared statement of Jeremiah Sheehan follows:]

PREPARED STATEMENT OF JEREMIAH SHEEHAN

I am Jeremiah Sheehan, a former employee and patient of Manhattan Bowery Corporation.

I thank you for this opportunity to testify today on the problems of alcoholism among the aging.

I am a recovered alcoholic with three months sobriety. I am 66 years old. I had had eight years sobriety before my relapse three months ago. I would like to address the followng from personal experience.

1. As you become older alcoholic drinking espisodes become more life threatening.

2. Contrary to popular opinion, change is still possible for older alcoholics through access to proper treatment, and A.A.

I do think that reaching out to the older alcoholic is very important.

When a person feels isolated and alone there is an inclination to hopelessness, i.e. feeling that you cannot change. Friends and family reaching out, helps you to change your outlook.

Ms. FERRARO. Ms. Kiernan.

STATEMENT OF ELIZABETH KIERNAN

Ms. KIERNAN. Good morning, Bishop Sullivan, Congresswoman Ferraro, Congressmen Pepper and Biaggi. I am Elizabeth Kiernan, the director of Nursing Services at the Manhattan Bowery Corp., an alcoholism treatment agency which treats public alcoholics. I am also the chairperson of the Mahattan Committee on Alcoholism.

Most of the elderly are in a category of well elderly, not in nursing homes or chronic hospitals, and not homebound. Well elderly does not necessarily mean illness free; it is estimated that 85 percent of the elderly have some form of chronic illness.

Alcoholism is a chronic progressive disease present in all segments of the population. It is a treatable disease with signs and symptoms by which it can be diagnosed.

There are an estimated 500,000 problem drinkers in New York City and it is estimated that only 8 percent of this group receive alcoholism treatment services in existing alcoholism treatment agencies and programs. The elderly are one of the most underserved groups.

Most elderly on fixed incomes cannot afford routine health care. This makes earlier diagnosis of alcoholism by health professionals less likely. Others, for example, peers, family and those engaged in running senior citizen centers and programs may not know how to recognize earlier stage alcoholism and intervene successfully.

Later stage alcoholism appears hopeless to many, although I assure you it is not. Having worked on Manhattan's Bowery for 15 years, I want to tell you that later stage alcoholism is treatable. It is just best to get it as early as possible. Knowledge of intervention and confrontation techniques and appropriate referral sources are necessary.

Two problems come together here: First, the need for the elderly to have more access to health maintenance and health education; and second, the need for health professionals involved with the elderly, in their health maintenance to know about alcoholism.

It is necessary for those involved with the elderly on a regular basis to learn about alcoholism, as it is necessary for the elderly themselves to learn about alcoholism.

Alcoholism is a major national health problem. It kills like hypertension, diabetes, and cancer. And just as hypertension and diabetes are managed in the elderly population, alcoholism can be managed.

Ms. FERRARO. Thank you very much. I truly want to thank the panel for their testimony. I guess what happens down in Washington, very frequently when we are dealing with legislation, when we are dealing with problems, we talk about numbers. Whether they are dollar numbers or people numbers, they are many times just numbers. And what you three people have done today, to have come forward, as did Jason Robards, you have really humanized the problem for us. To recognize the fact, by us, that we are deal-

ing with real people. Real people who recognize the problem, who understand you are out to help others so that those who are into the drinking will remove themselves from it.

I just have one question for you, Mr. Sheehan. You said two-thirds of the elderly alcoholics are closet drinkers. Where is that figure from?

Mr. SHEEHAN. That was strictly a personal opinion. I do not have any figure to back that.

Ms. FERRARO. OK. But that is what your estimate is?

Mr. SHEEHAN. It definitely is. And from personal experiences, I have run across people approximately my age, and I am amazed, I have seen them perhaps in a bar, a few beers, that is it. However, they do their heavy drinking in their room, their apartment, whatever, wherever they live.

Ms. FERRARO. How do we reach them?

Mr. SHEEHAN. I do not know.

Ms. FERRARO. Do you do it through family?

Mr. SHEEHAN. I do not believe I could say yes to that, I do not know. I think it is a question of each individual making up his own mind to a problem. If he can recognize it originally, it is best but that is hard.

Ms. FERRARO. That is probably what Jason Robards was saying. He said that the number is 10 million, but there are many.

Mr. SHEEHAN. I agree with him 100 percent. I believe it is correct.

Ms. FERRARO. Thank you very much.

Mr. PEPPER. Mr. McNamara, you and Mr. Reinhart made two of the most dramatic statements I have ever heard of your experience. I did not learn from Mr. Sheehan, as I would like to ask him. But in your case, Mr. McNamara, as I inferred from your statement, your drinking began when you retired. You had more idleness and nothing very much to do. Is that true?

Mr. MCNAMARA. A slight correction. I drank I imagine from the time I was in college more or less as part of my daily routine. It was not necessarily a daily routine, but more social routine, in the sense that my meals began with cocktails, I had wine during the meal and a drink afterward, and occasionally I would go for a night on the town. But I was able to tolerate the alcohol.

I would say in the last 6 years of my drinking period, I was no longer in control. I had to drink. I did not particularly care to drink because most of that time I was living on social security and my taste was for brandy. At roughly $5 to $6 a bottle a day, $300 does not last very long. In addition to that, there are certain things like taxes, rent, food, clothing, and so on, that pretty much go by the board because the important thing is the drinking. But simply for the money, the alcoholic will not admit he has a problem. The family tends to overlook it or say, "Well, the poor dear, that is all he gets out of life." I felt I could not live without alcohol.

Mr. PEPPER. You said it was your best companion who confronted you. .

Mr. MCNAMARA. Very much so. And the two doctors, again, that I saw, that prescribed Valium and Librium. I had the unfortunate awareness that there was a young lady in New Jersey who was dying very slowly from alcohol and Valium. I did not want to give

up my drinking by mixing with Valium, so I never took the Valium or the Librium. When I finally gave up the drinking, I threw the stuff away. I accumulated the drugs, I even bought prescriptions, but I never used them because I wanted nothing to interfere with my drinking.

Mr. PEPPER. I have a rather serious question. I know you heard me say I am 82 years old. I have been very busy. I have been in Congress 20 years and a little over 20 years in the House.

If I had stopped challenging work, I am a lawyer by profession. I guess if I had not been in Congress, I would have remained active as a lawyer, but I can imagine the problem that a person has. My sister today has been out of the hospital for about 3 or 4 weeks. She is in my apartment. She is gradually getting over depression. She retired after 38 years of school teaching and then she did not have anything to do. She had enough pension and social security to live on with what I would give her from time to time. But she began to get lonesome. She just did not have anything to occupy her mind.

She began to go to the hospital. She began to think she had terrible illnesses of one sort or another, and she has been in the hospital a dozen times, I guess. Finally now, she seems to be responding to medicine to get her out of her depression. We are trying to get her active. I try to get her to go with me. She gets up in the morning, has breakfast, goes right back to bed, stays in bed until noon, gets up and has lunch, goes back to bed and stays there until dinner, gets up, eats dinner, goes right back to bed. She gives all sorts of excuses, like her stomach is not feeling well. She urges me let her lie down just a little while, but I try to urge her up.

It is a serious problem. She is 71 now. It is a serious problem for elderly people when they do not have anything to do to challenge them. Some of them do not have the benefit of a pleasant, friendly association with a large number of other people.

That is why we encourage people to keep on working if they want to, even part time. If they do not work earning money, they should try to take up some sort of avocation or hobby. The goal is to be doing something.

Now, the other day I was visiting at an elderly home in central Florida. I came to a room of one couple, elderly people. The man had been a prominent man. He had a good job. He retired at 65 and moved to that nursing home. He had a beautiful outlay there of birds that he had made out of wood. They were beautiful in shape, just like birds that would be drawn by an expert artist. He had gotten interested in doing that. And he started it at 65. It kept him busy. It does not make too much difference what you do, as long as it is honorable. Keep yourself occupied.

Do you think that would be helpful to avoid alcoholism to the elderly?

Mr. MCNAMARA. If one can find it, it would be helpful. In my own case, I started work when I was 67 and I worked until I was 71; as a result my time was occupied. I had something to do and I was being, I hope, helpful to other people. The aspect was always in the front of my mind that there are so many out there who are not being helped because they do not know where to go.

Mr. PEPPER. Mr. Reinhart, in your case you have suggested that you were a successful man. You had pleasant associations. Your

very success, in a way, contributed to your alcoholism because so many other people were doing it and you first joined in with them as a social drinker. That is the way you started. After you got more and more addicted, the alcohol itself began to be a pull, I guess. It pulled you into excess. Is that the way you described it?

Mr. REINHART. Exactly, sir. Yes. I would like to take this opportunity to remark on something you said about keeping busy. You hit the nail on the head. I am 66. I am semiretired. I have a loving wife and family and grandchildren. That is not enough. You have to keep busy.

We feel at my age, 50, 60, I am 66, there are golden opportunities. If we are alcoholics, and I am one, there is a golden opportunity to get into detox centers and talk to people, share our personal experiences. There is no cure, but there is a way of stopping it and holding it. It is an insidious disease that lays in wait. It waits for people who are hungry, lonely, tired, and angry.

Nursing homes, you mentioned nursing homes. Many, many nursing homes are dying for volunteers. I go as often as I can. I read to some. I tell jokes to others. I just talk. I just touch some. It is fulfilling At the detox centers they are always looking for volunteers. Thank you for reminding me that you have got to keep busy.

Mr. PEPPER. If you do not mind, Ms. Ferraro, in speeches sometimes to the elderly, I like to accentuate and to emphasize that the elderly think of themselves as having a future as well as a past. I encourage them not to give up, to be busy with something, to have some plans, some dream. Well, now I have a chance to do something I never had time to do before. What a wonderful time I am going to have doing it. I spoke these lines. You might read them from time to time. They are encouraging to me.

The lines are by Tennyson. They say,

> Death closes in, but something near the end. Some work of noble note may yet be done by men who once strove with Gods. Come my friends. It is not too late to seek a new world. Push on. And smite the sounding forest. For my purpose holds to sail beyond the sunset and past all the western skies until I die.

Ms. FERRARO. Let me just turn to the bishop.

Bishop SULLIVAN. This is like following Socrates. I was very impressed, as the Congressman was, with the testimony. And just one question and maybe some comment from the panel.

Do we know how many people begin drinking when they retire and are no longer gainfully employed? And what are some of the things we might do? Is that the case or is it just the end result of a long pattern of drinking? Or are there people who begin only after retirement to drink excessively?

Ms. FERRARO. Anyone on the panel can take it, if you just take the mike.

Mr. REINHART. A very good question, Your Excellency. I do not know the answer. Unfortunately, I do feel if enough publicity got out there to community centers and other organizations, which Geraldine would have much more knowledge of, to let them know that there is help and there is hope. The first step is to get them into a hospital where—incidentally, I hate to bring up money, but 5 days in a detox center at $300 a day, $1,500, is well spent if it is going to get a man or a woman back from a drunk or a lush, into a lady or gentleman.

Mr. McNAMARA. Just one point. Probably most people drink socially until retirement sets in. I think the Members of Congress, who passed the 18th amendment, might recall that it banned intoxicating beverages. Intoxicating in my dictionary means poisonous. And maybe it would be a good idea to label these containers as containing a poisonous substance.

After all, we find that one of the nastiest aspects of senior citizens is being depressed. And although alcohol is generally advertised as being a terrific stimulant, ultimately it is another depressant. Alcohol only depresses. So if you are depressed to start with, alcohol is going to make you that much worse.

I found in my own case, at the end, I just did not care anymore. I was ready to take the easy way out because the alcohol that I depended on was a depressant.

Ms. KIERNAN. Alcoholism is a progressive diseas , and for some people the progression is very quick. So that you might find someone who started drinking at 15, who lost control of their drinking with their first drink. Others might start drinking in their 20's or 30's and take 20 or 30 years. Others may have not had an opportunity to drink and may begin with relief drinking and never know that they had a propensity for alcoholism.

There are hallmarks. There is a general feeling that if you have one parent or two parents who are alcoholic, that you might have a higher chance of becoming alcoholic. The actual statistics may be helpful, I have never seen any, but it is good to consider all of the things that I have mentioned.

Bishop SULLIVAN. Thank you very much. Just one comment. I think the purpose of this kind of center is precisely to provide the kind of socialization that I think the Congressman was talking about. You see paintings around here—people do all kinds of knitting and artwork, and sculpturing. There is an opportunity here to come, and to sing, and to dance, and to socialize, and have meals together. All of that is to combat what I think is the great enemy of all of us, loneliness. And I think that is the purpose of the center and that we have so many of our people come out, because it is a way that they share. I think the Congressman is challenging all of us to use our skills, our talents, productively, and to continue to be challenged.

Mr. PEPPER. I want to ask this question at this time. At a treatment center, do you get that care through medicare?

Ms. KIERNAN. Our particular treatment center is funded through New York City funding, the Bureau of Alcoholism Services. And it is a center for public alcoholics. The detoxification unit is paid for by the city and it is not reimbursed.

Mr. PEPPER. Do you know whether medicare affords any of that treatment or not?

Ms. KIERNAN. I really do not know what medicare covers. At our agency medicare does not afford treatment.

Mr. PEPPER. But it does provide for psychiatric care? Is that so? A member of our staff says it is under psychiatric care. Ms. Ferraro and I are going to look very carefully into that to see whether or not there are treatment programs actually available to the elderly citizens of the country and if they are as readily accessible as they should be.

Mr. McNAMARA. Congressman Pepper, if I may, I do believe medicare does cover treatment for alcoholism at the present time. It is also treated under Blue Cross/Blue Shield, under certain restrictions.

Ms. FERRARO. The coverage, as we understand it is under medicare part A, the detoxification. We have just been discussing with staff, and you see us whispering over here. We were just talking about the possibility of raising the limitations that are currently under the medicare bill. That would be available to anyone who really needs it for the length of time necessary because your point about how costly it is, as much as it is a cost effective thing, it is a good investment to get people out of a cycle of alcohol abuse. Facing $300 a day is very hard for people to handle.

Ms. KIERNAN. A stay at an alcohol treatment center might not be $300 a day, but that is not reimbursable oftentimes through medicare. And that might be something interesting to look into because many people can be detoxified in a social setting or a sober up station model.

Ms. FERRARO. I cannot tell you how terribly grateful I am to each of you for your testimony. Thank you so much.

Our next panel is Dorothy Phelan and Karl Nelson, and I promise you we are going to stick with the time limits on each of the panels for 15 minutes. I am going to ask you to speak quickly.

Dorothy Phelan is chairperson of the New York City Committee on Women and Alcoholism, and she is a member of the New York State Alliance of Task Forces on Women and Alcoholism.

I have to tell you, several months ago I was a keynote speaker at a conference on family life and alcohol abuse, which was held under the leadership of Dorothy Phelan, and it is because of my involvement in a question and answer period after that speech that these hearings are being held. Because the problem certainly was brought up during the course of that seminar.

With her at the table is Mr. Karl Nelson, who is currently the executive director of Bird S. Coler Hospital here in New York. He spent 25 years in the Salvation Army and was executive director of Booth Memorial Hospital, which is also right here in Flushing, so I welcome them both and I will hope to put your entire statement into the record, if you would like to summarize, because our seniors have lunch.

PANEL 2, CONSISTING OF DOROTHY PHELAN, CHAIRWOMAN OF THE NEW YORK CITY COMMITTEE ON WOMEN AND ALCOHOLISM; AND KARL NELSON, EXECUTIVE DIRECTOR OF BIRD S. COLER HOSPITAL, NEW YORK

STATEMENT OF DOROTHY PHELAN

Ms. PHELAN. My remarks are short. And some of my comments have been touched by the other speakers.

Good morning. My name is Dorothy Phelan and I am the chair of the New York City Committee on Women and Alcoholism. We are a membership organization, concerned community members and professionals, and our purpose is to advocate on alcoholism issues, specifically as they relate to women. We would like to thank Representative Ferraro for her action in following up on the con-

cerns raised at the meeting in February, and Senator Pepper for joining us here today. This is a most serious, yet hidden problem, that is, alcohol among older persons.

As Betty Kiernan had noted, there is an estimated 500,000 persons in New York City alone with alcoholism. The disease of alcoholism costs this city an estimated $1 billion a year, yet only 8 percent of those in need are now receiving services. And of the total number of people in treatment for alcoholism, only 4 percent are 65 years and older.

This may suggest a lower incidence among those 65 years and older, but there is little definitive research. However, the ravages of alcoholism do take their toll and one of the tolls is often a shortened lifespan.

However, there are other phenomena indicating that we may be missing some important clues to identifying alcohol among the elderly. There is evidence that there is late onset alcoholism. Harmful drinking undertaken in response to health problems, loss of spouse, retirement adjustment, isolation and loneliness.

Second, alcoholism is a chronic disease, where affected persons, even those who receive treatment, may experience relapse. Even with frequent relapses, treatment has been shown to be beneficient and does prolong life.

Third, we have a growing awareness about problems ensuing from alcohol used concurrently with legitimately prescribed medication. Thus, an individual may unwittingly experience a serious, even life threatening reaction, by drinking alcohol while using prescribed medication. In some instances, particularly noticeable when alcohol and minor tranquilizers are used, dependence or addiction may result. Older persons tend more often to require medications and are therefore especially vulnerable. Thus, the extent of alcohol related problems may be significantly higher than originally believed.

What we do know is that older persons with alcoholism are heavy users of the health care system, treated and frequently hospitalized and rehospitalized, but for other diagnoses, and the alcohol problem is unobserved, unaddressed and untreated.

A prevalence study done at Harlem Hospital found a high incidence among hospital patients. Screening newly admitted patients, they determined that 63 percent of males and 35 percent of females in the 50- to 69-year-old age bracket were alcoholics.

Dr. Sheldon Zimberg, an expert in this area, also studied 1,636 admissions to a federally funded suburban community mental health center. Only 5.3 percent of the admissions were 65 and over, but 17 percent of these older persons exhibited alcohol abuse problems.

Based on these figures, we can conclude that over-65 alcoholics are significantly underrepresented in treatment programs; the costs of untreated alcoholism to Federal programs, like medicare, is high in the millions.

I would like now to turn to some specific observations about women. There is a stigma associated with abusive and alcoholic drinking, even more so for women drinkers.

Older women have been acculturated to norms which discourage nice ladies from drinking too much or frequenting bars. Women,

especially older women, therefore, often drink secretly, alone in their homes. They take care to hide all evidence of their problem when outside, and even sometimes among their families for as long as possible.

Symptoms may be dismissed as nervousness, anxiety and depression, symptoms often readily accepted, even by their own physicians.

Older women with active alcoholism have more difficulty in following treatment regimes for other medical problems, experience more difficulty in coping with problems of daily living than a nonalcoholic contemporary. They are easier targets for muggings, thefts, and assaults.

Though her alcoholism may go unnoticed by her physician, her symptoms may be mistakenly diagnosed as psychiatric in origin. And even when the alcoholism is identified, she is often adjudged to be sicker than her male counterpart, although this is not so.

The older woman's alcohol related symptoms are mistakenly associated with onset senility, forgetfulness, poor attention span, and blackouts. The slip in the tub, the fall on the stairs, and similar accidents get chalked up to the vulnerability of aging, when often they are directly related to excessive alcohol consumption.

Before I offer some recommendations, I wish to highlight one other group of women who suffer terribly from alcoholism. These are the family members and significant other persons, the nondrinking loved ones, whose lives are as much bound up in the disease as the drinkers. The older woman may be the wife, and more often the widow, of an alcoholic husband. If her partner's drinking extended throughout their marriage, she carries to her later years a legacy of broken dreams, emotional and physical battering and often unnecessary guilt that she had contributed to the drinking or at least could have done more to stop it, a heavy heart that remains even when the spouse has passed on.

Alcoholic families are isolated and dysfunctional. The significant other woman may have lost contact with her friends, family, and community over the years. She may not readily socialize, join her senior peers in activities, just because the drinker is no longer there. Alcoholism also takes a heavy financial toll. The surviving spouse, especially the woman who has not worked outside the home may be heir to debts, reduced or lost pension benefits, and virtually no savings.

Children in alcoholic homes often place blame on the nondrinking parent. The older widow of an alcoholic may thus find herself estranged from her children and bereft of her family support system. Moreover, children of alcoholics are at high risk, and the figure is 50 percent that children of alcoholics tend to develop alcoholism themselves.

A wife may suffer during the long years of her husband's disease only to survive him and then one or more of her children develop alcoholism. These women are rarely spoken about when alcoholism problems are investigated.

The congressional committee has taken an important step by conducting this hearing. Information and public awareness are critical first steps in our fight.

Other recommendations include: To significantly increase the amount of training about alcoholism for physicians and nurses; to require initial and continuing education about alcoholism for all certified health and mental health professionals. Many now receive none in their professional training. To mandate alcoholism consultation services in all hospitals as part of certification requirements and include these costs in the basic cost of services provided. The Federal Government should pay special attention to this issue in light of medicare payments and expenditures in veterans hospitals.

Identify funding resources to further research in this area. Develop resources to foster linkages between health and social service programs like this one here, wnich serves the elderly and the alcoholism services network.

Alcoholism outpatient services must develop treatment and services that are sensitive to the needs of older persons. At present services tend to be geared toward a younger population.

The overwhelming majority of elderly persons who do receive alcoholism services in New York City are served in the acute care system. They are significantly underrepresented in aftercare and outpatient population. We need intermediate care alcoholism rehabilitation services for older persons fostering a continuity of care and improved prognosis for extended recovery so that they may participate in less restrictive, less costly services.

About 50 percent of the elderly receiving alcoholism treatment in New York City are now in programs serving the disaffiliated, often homeless persons. More long term supports, both residential and outpatient, are needed to foster extended sobriety and to offer to these older citizens an alternative to living in streets and doorways.

More patient education is essential regarding the use of alcohol along with prescribed medications.

Alcoholism outreach into adult homes must increase. New York City has now two programs like this that were instituted over the past year and the results are very promising.

Special outreach to older women is required. Alcoholism programs should have resources to work with community medicine teams, visiting nurses, meals-on-wheels and other such programs that go into the home.

The New York City Committee on Women and Alcoholism asks that this congressional committee continue its investigation into the problem of alcoholism. It is clear we do not have enough information or factual data. Our committee offers to work with you in any way we can be helpful

Also in New York City there are alcoholism advisory committees in each borough, as well as other professional organizations that we know will also help. Thank you.

[The prepared statement of Dorothy Phelan follows:]

PREPARED STATEMENT OF DOROTHY PHELAN, CHAIRPERSON, NEW YORK CITY COMMITTEE ON WOMEN AND ALCOHOLISM

Good morning! My name is Dorothy Phelan. I am the chairperson of the New York City Committee on Women & Alcoholism. We are a membership organization comprised of community members and concerned professionals. The purpose of the Committee is to advocate on alcoholism issues as they relate to women.

We are especially pleased to be present at this important hearing. We wish to express our thanks to Rep. Ferraro, Rep. Pepper and Rep. Biaggi for focusing attention on this serious, yet hidden, problem—alcoholism among older persons. Our concerns extend to all older persons suffering the effects of this disease; our special interests are the needs of women.

There are an estimated 500,000 persons in New York City with alcoholism. The disease of alcoholism costs the City of New York an estimated $1 billion each year (through lost productivity, lost wages and taxes, increased social services costs, etc.). Yet only 8 percent of those in need receive services per year. Of the total number of persons in treatment only 4 percent are 65 years of age or older.

This suggests a lower incidence among those 65 years and older. There is little definite research. However, the ravages of alcoholism do take their toll, often in a shortened life span. Alcoholics frequently succumb before reaching their senior years, perhaps accounting in part for a suspected lower incidence.

However, there are other phenomena indicating that we may be missing the clues to alcohol problems among older people. First, we are now learning that there is late onset alcoholism, harmful drinking undertaken in response to health problems, loss of a spouse, retirement adjustment, isolation or loneliness. Second, alcoholism is a chronic disease where affected persons receive treatment but experience relapses. Even with frequent relapses, treatment, detoxification, has a beneficient effect and, I believe, prolongs life. Third, we have a growing awareness about problems ensuing from alcohol used concurrently with many other legitimately prescribed medications. The individual may unwittingly experience a serious—even life threatening—reaction by drinking alcohol while using prescribed medication. In some instances, particularly noticeable when alcohol and minor tranquilizers are used, dependence or addiction may result. Older persons tend more often to require medications and are, therefore, especially vulnerable. Thus, the extent of alcohol-related problems among older persons may be significantly higher than originally believed.

What we do know is that older persons with alcoholism are heavy users of the health care system, treated and frequently hospitalized and rehospitalized, for other diagnoses, the alcohol problem unobserved, unaddressed, untreated.

A prevalence study done at Harlem Hospital (McCusker, Cherubin & Zimberg) found a high incidence among hospital patients. Screening newly admitted patients, they determined that 63 percent of males and 35 percent of females in the 50 to 69 yr. old age bracket were alcoholics. Dr. Sheldon Zimberg, an expert in this area, also studied 1,636 admissions to a federally-funded suburban community mental health center. Only 5.3 percent of the admissions were 65 or over. However, 17 percent of these older persons exhibited alcohol abuse problems. Based on these figures we can draw a number of conclusions including (1) over 65 alcoholics are significantly underrepresented in alcoholism treatment programs and (2) the costs of unrelated alcoholsim to federal programs, like Medicare, is nigh in the millions for repeated hospitalizations, long term care and other health care reimbursement while the alcohol problem goes unaddressed.

I would like to turn now to some specific observations about women. There is a stigma associated with abusive and alcoholic drinking—even more so for women drinkers. Older women have been acculturated according to norms which discouraged "nice girls" from drinking too much or frequenting bars. Women, especially older women, therefore, often drink secretly, alone in their homes. They take care to hide all evidence of their problem when outside, or, even among their families, for as long as possible. Symptoms may be explained aware as nervousness, anxiety, depression—readily accepted even by their physicians.

Older women with active alcoholism may have more difficulty in following treatment regimes for other medical problems, experience more difficulty in coping with problems of daily living than their non-alcoholic contemporaries. They are even easier targets for thefts and assults. Though her alcoholism may go unnoticed by her physician, her symptoms may be mistakenly diagonosed as psychiatric in origin. Even when the alcoholism is identified she is adjusted to be sicker than her male counterpart.

The older women's alcohol related symptoms are mistakenly associated with senility—forgetfullness, poor attention span, blackouts. The slip in the tub, the fall on the stairs and similar accidents get chalked up to the vulnerability of aging. Often, they are directly related to excessive alcohol consumption.

Before, I offer some recommendations I wish to highlight one other group of women who suffer terribly from alcoholism. These are the family members and the significant other persons, the non-drinking loved ones whose lives are as much bound up in the disease as the drinkers'.

The older woman may be the wife—more often the widow—of an alcoholic husband. If her partner's drinking extended throughout their marriage she carries to her later years a legacy of broken dreams, emotional and/or physical battering, and often, guilt that she had contributed to the drinking or, at least, could have done more to stop it—a heavy heart that remains even when the spouse has passed on.

Alcoholic families are isolated and dysfunctional. The significant other woman may have lost contact with her friends, family, community over the years. She may not readily socialize, join her senior peers in activities just because the drinker is no longer there. Alcoholism often takes a heavy financial toll. The surviving spouse—especially the woman who has not worked outside the home—may be heir to debts, reduced or lost pension benefits, virtually no savings.

Children in alcoholic homes often place blame on the non-drinking parent. The older widow of an alcoholic may, thus find herself estranged from her children, bereft of her family support system. Moreover, children of alcoholics are at high risk to develop alcohol problems themselves. A wife may suffer during the long years of her husbands disease only to survive him and then watch one or more of her children develop alcoholism.

These women are rarely spoken about when the alcoholism problems are investigated.

The Congressional Committee has taken an important step by conducting this hearing. Information and public awareness are critical first steps in our fight against alcoholism.

Other recommendations include:

Significantly increase the amount of training about alcoholism physicians and nurses receive and require continuing education in this area.

Require initial and continuing education about alcoholism for all certified health or mental health professionals. Many now receive none.

Mandate alcoholism consultation services in all hospitals as part of certification requirements. Include the costs in the basic services provided. The federal government should pay special attention to this issue in light of medicare payments and expenditures in veteran's hospitals.

Identify funding resources to further research in this area.

Develop resources to foster linkages between health and social service programs which serve the elderly and the alcoholism service network.

Outpatient alcoholism services must develop treatment services that are sensitive to the needs of older persons. At present services tend to be geared toward a younger population.

The overwhelming majority of elderly persons who do receive alcoholism treatment in New York City are served in the acute care system. They are significantly underrepresented in the aftercare or outpatient populations. We need to develop intermediate care alcoholism rehabilitation services for older persons, fostering continuity of care and improved prognosis for extended recovery and participation in the less restrictive, less costly outpatient services.

Almost 50 percent of the elderly receiving alcoholism treatment in New York City are in programs serving the disaffiliated, often homeless person. More long term suports, both residential and outpatients are needed to foster extended sobriety and to offer to these older citizens an alternative to living in streets and doorways.

More patient education is essential regarding use of alcohol during a course of treatment with prescribed medication.

Health and human services workers must learn about how alcoholism affects families to better understand and address the needs of significant others.

Alcoholism outreach into adult homes must increase. New York City has had two programs like this over the past year. The results are promising.

Special outreach to older women is required. Alcoholism programs should have resources to work with community medicine teams, visiting nurses, meals-on-wheels and other such programs that go into the home.

The New York City Committee on Women & Alcoholism asks that this Congressional Committee continue its investigation into the problem of alcoholism. It is clear we do not have enough information or factual data. Our committee offers to work with you, in any way we can be helpful. In New York City there is also an alcoholism advisory committee in each borough as well as other professional alcoholism-focused associations that we know will also be willing to help.

Thank you.

Ms. FERRARO. Thank you very much.

Mr. Nelson.

STATEMENT OF KARL NELSON

Mr. NELSON. Chairman Pepper, Congresswoman Ferraro, Bishop. It is a privilege to have been asked to testify today. My name is Karl Nelson and I am the executive director of Bird S. Coler Hospital, an affiliate of the New York City Health and Hospital Corp., which combines a skilled nursing facility of 775 beds and an acute care hospital of approximately 270 beds, providing care primarily for people with chronic diseases.

As was stated in the introduction, I spent 12 years at Booth Memorial Hospital in Flushing, where we began an alcoholic detoxification unit and an alcoholism clinic. In that neighborhood our concern was primarily for working men who were alcoholics. Most of our referrals came from labor unions. We were also concerned with women, particularly housewives.

It was not until I came to Coler Hospital last year that I developed a realization that alcoholism in the elderly was just as much, if not more of a problem, than in the working population, so I am particularly pleased to be here today.

I attended a recent presentation given by Dr. Karl Isedorfer, president of Montifiore Medical Center, and one of the leaders in the field of geriatric medicine. And he stated that in his opinion, the second leading medical problem for the elderly, following the problem of too many and inappropriate combinations of drug prescriptions was the problem of alcohol abuse.

As the manager of a chronic care facility of nearly 1,100 patients, I can second that opinion. I have to face on a daily basis the management problems that are caused by alcohol.

The patients at Coler are there because they have deteriorating clinical diseases, strokes, amputations, spinal cord injuries, paraplegia, Parkinson's, cerebral palsy. Many of these diseases in fact mask the problem of alcoholism as each of you made reference to in your opening comments.

So many of our patients are there with diseases that are stress-related, that have emotional backgrounds to them. Many of our patients who have spinal cord injuries as the result of automobile accidents. Alcohol is involved in many of these but there is no way for us to diagnose that.

I was particularly impressed by Mr. McNamara's previous testimony when be talked about being admitted to hospitals clearly with a drinking problem, and having it diagnosed as gastrointestinal. I think a primary problem today is that doctors will not or cannot recognize alcoholism, will not diagnose it, and prefer to diagnose other diseases. And I would second what you said, Dorothy, about education for physicians is primary because even they will not recognize this problem.

Because of the multiple nature of their disabilities, 80 percent of my patients are wheelchair bound. The long term nature of their chronic diseases and the fact that so many of them have nowhere else to go create an exceedingly long length of stay.

Adding these factors together, multiple disabilities, chronic diseases with little or no hope of cure and excessively long institutionalization, it is no wonder that alcohol is a problem. In our population we have identified between 60 and 70 patients as chronic alco-

hol abusers, about 6 percent of our total population. The alcohol complicates the diagnosis. It makes their treatment plans exceedingly complicated. In fact, very often it means that we cannot develop an appropriate treatment plan because of the interaction between the alcohol and other medications.

The impact on our cost is phenomenal. There is no way for us to estimate how much the length of stay is increased because of alcohol, but we know it has increased. As you on this committee well know, that is where the money goes.

It creates particular types of problems with our patients. The first type of problem is the antisocial behavior that develops because we have incidents of physical violence against staff members, patients who fight, threats to very frail, elderly patients, which are all alcohol related.

Just recently we had a known drinker who accidentally set himself on fire in bed. We have patients who journey into the nearby village on Roosevelt Island and cause a great deal of disturbance to the residents because of the alcohol.

Alcoholic patients often steal the belongings of other patients so they can buy liquor. And then we have a large number of patients who we cannot discharge from our facility because of their alcohol problems. They will not be accepted in other forms of residences, which would be less expensive forms of residences; because of the alcohol, we cannot discharge them.

That is one type of problem caused by alcohol. But there is another kind of problem, and I think this relates to what Mr. Sheehan was referring to before.

Of our 60 to 70 identified alcoholics, approximately half of them do not create behavior problems for us. They stay in bed and sleep all day. They withdraw from society, just as the previous panel discussed. Mr. Sheehan could not give you a statistic, but of our identified alcoholics, it is just about half who do not exhibit any antisocial behavior; they just withdraw completely.

It appears to me that for the purposes of this committee hearing, that type of alcoholic in the elderly population may be the one who needs to be seriously considered. You asked the question, How do you identify them? I am sorry, Bishop. I do not have answers.

Why does the problem exist particularly in elderly patients? I think, again, I will go back to Dr. Isedorfer. In his private practice, he said that many of his patients who were over the age of 65 who had alcohol problems developed that problem after they reached the age of 65.

It was his feeling that the lack of appropriate goals for their lives, not looking ahead. Congressman, the inability to make their own decisions about what they do with their lives, both within and outside institutions. And the fact that the elderly in our society have been traditionally and still are considered to be some form of second-class citizen, doing little more than draining our social security resources. It is his feeling that it is these factors which do cause the elderly to begin to drink. It is the problem of how the elderly are treated in society; the importance that we as individuals place upon senior citizens; the status of appropriate dignity that is provided for our aged population.

If appropriate living conditions could be provided, if adequate socialization programs could be made available, like this one here, if Social Services could be conducted with an appropriate amount of dignity, then the elderly population of this country might again begin to feel that they are fully participating members of society. In the absence of those factors, they will find release through a variety of other mechanisms. A primary one of those releases will be and has been substance abuse. In the confines of the long term care institution that I represent, these problems are compacted. They become much more real, much more immediate, much more threatening.

In term of potentials for solution, we at Coler are beginning an alcoholism training program for our staff. We are working in cooperation with Ms. Phelan's agency. The New York City Department of Alcoholism Services is working with us to provide funding for alcoholism counselors. A primary function of these individuals will be to provide a different kind of attitude, a sensitization for our other employees toward our patients who have alcohol problems, in addition to bringing technical training in how to work with alcoholics.

Our plans then would be to develop an intensive therapeutic counseling program for alcoholics, and hopefully in the near future, to have detoxification beds.

I must give recognition to Ms. Phelan's agency and also to the Health & Hospitals Corp. that has given support for staff training.

You asked about funding. There is funding for inpatient detoxification care, but that is the end of the line. There is virtually no funding, except through the city, but very little from medicare and medicaid, for outpatient care, for identification, for early treatment and diagnosis. That kind of funding is badly needed.

We are also living in a day and age when Congress and other agencies are talking about budget cuts for health care. They are clearly important. However, when budget cuts are made for health care, there are many things that will not be cut. You will not cut dialysis treatment. It is lifesaving. You will not cut emergency rooms. You will not cut ambulances. You will not cut open heart surgery. You will not cut the dramatic things that keep people alive, but I am sorry to say the area where cuts may be most vulnerable are in areas like the early treatment and diagnosis of alcoholism because nobody is going to die tomorrow if that cut is made.

I would strongly urge you to attempt to keep funding for these kinds of programs. The true solution for this problem does not lie within the health care system. It is a problem of society as a whole.

I would strongly urge this committee to continue your good work in the provision of housing, employment, socialization activities, life enrichment programs, and other positive moves that are designed to make senior citizens truly functioning members of our society. That will be the only way to combat alcoholism. We in the health care system are only putting band-aids on the end result. Thank you very much.

Ms. FERRARO. I have no questions, but I just want to say, both of your testimonies were absolutely superb. You were very specific on the problems and very specific on your recommendations and I can assure you that this committee will certainly look into both.

Mr. PEPPER. In the first place, I wish both of you were Members of Congress. You could help us with what you have recommended here. I sometimes feel that so many, I almost feel like Jesus on the cross, Father, forgive them, for they know not what they do when they make all those cuts.

We are trying to restore some of the cuts that have been made. We hope to stop them in the future and to do other things that need to be done for the betterment of the people of this country. We congratulate you on your fine statements.

Ms. FERRARO. Thank you. Moving right along, our next panel is Ms. Marguerite Saunders, who is deputy director, in Division of Substance Abuse Services for the State of New York. She has been since 1976. In 1978 she developed the Commission on Prescription Drugs Misuse and its subcommittee on the elderly. Also on the panel, Dr. Phillip Zeidenberg, acting director of the Research Institute on Alcoholism in Buffalo, N.Y. He has been with the Research Institute since 1982, and is also with the Department of Psychiatry at the State University of New York, Buffalo.

Accompanying Dr. Zeidenberg is Dr. Ernest Able. He is the acting deputy director of the Research Institute on Alcoholism. He has been with the institute since 1973, and has devoted his efforts to studying the effects of alcohol during pregnancy and on the aging process.

I am delighted to have all three of you with us this morning.

PANEL 3, CONSISTING OF MARGUERITE SAUNDERS, DEPUTY DIRECTOR, DIVISION OF SUBSTANCE ABUSE SERVICES, STATE OF NEW YORK; DR. PHILLIP ZEIDENBERG, ACTING DIRECTOR, RESEARCH INSTITUTE ON ALCOHOLISM, BUFFALO, N.Y., ACCOMPANIED BY DR. ERNEST ABLE, ACTING DEPUTY DIRECTOR, RESEARCH INSTITUTE ON ALCOHOLISM

STATEMENT OF MARGUERITE SAUNDERS

Ms. SAUNDERS. I am Marguerite Saunders, deputy director for Program Services for the New York State Division of Substance Abuse Services. I would like to applaud the efforts of your committee and to express appreciation for your interest in the problems of the elderly, problems that are too frequently ignored by our society.

The focus of the hearing today is on alcohol and its relationship to the elderly. I am here to urge you not to view alcohol in isolation from other drugs. Our research has shown that about two-thirds of the elderly use drugs prescribed by their physicians and nearly 70 percent use over-the-counter products, primarily pain relievers.

Nearly half of them use these drugs in combination with alcohol and therein lies the danger. Of the 100 most frequently prescribed products, over half contain at least 1 ingredient that is known to react adversely with alcohol. Many nonprescription or over-the-counter products have the same effect. These drug/alcohol interactions can range from minor drowsiness to termination of the central nervous system function and even death.

The drug abuse network reports that 47,000 people who have used alcohol in combination with other drugs are treated every

year in hospitals and hospital emergency rooms. Of that group, 2,500 died.

When drugs are taken in combination with alcohol, the effects usually fall into one of four categories. The drugs may act independently of one another. For example, alcohol does not appear to interfere with the action of cortisone. Two, drugs taken together may have an additive effect. When two drugs elicit the same overt response, their combined effect is equal to that expected by simple addition 2 plus 2 equal 4. For example, codeine formula cough syrup and alcohol both have a sedative effect. If taken together it may result like taking two doses of codeine or two doses of alcohol.

Three, drugs taken together may also have a synergistic effect. This means that the joint effect of the two drugs is greater than the effect of the two drugs alone. For example, alcohol and antihistamines which are often contained in cold or allergy medications, produce an exaggerated sedative effect, and in this case 2 plus 2 will equal 5.

Finally, drugs taken together may have an antihystic effect. In these cases the joint effect of the two drugs is less than the drugs acting separately. For example, the antidiabetic drug, Orinase, acts this way when taken with alcohol. Here 2 plus 2 will equal 3.

The problem of drug/alcohol interaction poses special dangers for the elderly. First you must look at the sheer number of drugs taken by the elderly. Although constituting only 11 percent of the population, the elderly consume over 25 percent of the prescription drugs, and an even higher proportion of over-the-counter drugs.

The most commonly used drugs are for cardio-vascular conditions. And the second most commonly used drugs are sedatives and tranquilizers. Unfortunately, these groups of drugs have dangerous additive synergistic effects when taken in combination with alcohol. Furthermore, many elderly persons have one or more chronic diseases and take one or more maintenance drugs regularly. But the drug therapies are seldom coordinated by all the physicians who may be treating a patient. Additionally, doctors may not question their elderly patients on their alcohol consumption or about other drugs that are currently being used.

Physicians may not take the time to carefully explain to an elderly patient what drugs he has prescribed, when and how much of it is to be taken, what it will do, what side effects can be expected, and so on.

In turn, elderly patients are frequently reluctant to ask their doctors any questions at all and simply are not aware that their pharmacist, if asked, could supply any of the answers to these questions.

All of this increases the potential risk for a variety of adverse drug/alcohol interactions in the elderly. In addition, the elderly are unusually sensitive to drugs and alcohol. This sensitivity is associated with the different rates of absorption, distribution, metabolism, and excretion than for younger adults and increase the likelihood of adverse drug and alcohol interactions.

Finally, a crucial factor affecting drug and alcohol interactions is patients compliance with prescribed drug regime. The elderly patient may make errors in identifying which medication to take and at what time. Although younger patients frequently make the

same mistakes, the incidence among older patients is higher, due to poor eyesight, memory defects, and multiple ailments requiring medication.

Sometimes the elderly patient trades drugs with a friend or relatives hoping that a new drug will provide more relief or that possibly some money can be saved. They also retain unused drugs and self-medicate with them at a later date. All of these are failures to comply with the originally prescribed regime and may result in an adverse reaction if the elderly person consumes any alcohol.

Clearly the risks of using drugs in combination with alcohol are very high indeed, particularly for the elderly. Furthermore, let me stress that one need not be an alcoholic or even a problem drinker to experience unpleasant effects from mixing drugs and alcohol, or to discover that the two martinis taken before dinner are interfering with the effectiveness of the needed prescribed drug.

The human brain cannot differentiate between gin or Valium. So I am urging this committee not to differentiate between alcohol and other drugs, particularly when you examine it in relation to the problem of the elderly.

In addition, I would just like to make one other statement. The public generally thinks of the Division of Substance Abuse Services as primarily an agency concerning youth and drugs. But we are concerned with much more than that. We are interested in the drug welfare of all of our constituents. And given that, we did develop a committee on prescription drugs misuse. One of the parts of that committee is a subcommittee on the elderly for which we developed a great deal of resource material, a training package, a film, and many other services that we would be happy to advise. If anyone is interested in obtaining these services free of charge, we will be happy to work with any senior organization. There is resource material on that table and a telephone number and we will be happy to respond to your questions.

Ms. FERRARO. Thank you. You spoke very openly about prescription drug abuse. Representative Pepper has had hearings specifically on that subject and he will have some more in the near future.

Ms. SAUNDERS. Wonderful.

Ms. FERRARO. Dr. Zeidenberg, you are on.

STATEMENT OF PHILLIP ZEIDENBERG

Dr. ZEIDENBERG. Representative Pepper, Representative Ferraro, Bishop Sullivan, thank you for the opportunity of appearing here.

As you can see the problems associated with the use of alcoholic beverages among the elderly are numerous and complex. I cannot even begin to summarize the topic, let alone explore it in depth in the time allotted here. I would, however, try to outline at least some of the issues I think are relevant and which I think you should consider in your future deliberation.

First and foremost, I want to emphasize it is somewhat arbitrary to separate the issues of alcohol misuse and the general issue of its misuse by the elderly. Although there are very good arguments that can be made for dealing with the two issues separately, there are, in addition, important areas in which they have to be dealt with together. And those areas where issues must be addressed sep-

arately and where they must be addressed together must be clearly defined, so as to avoid duplication of effort without at the same time failing to address important issues which really should be kept as separate issues.

As I said, the issue of alcohol misuse, especially in the case of the elderly, perhaps more so in the case of the elderly, is difficult to separate really from other misuse. Such misuse involves several problems well known to those active in the growing field of geriatric medicine, but less well known to the general public and even to physicians specializing in other areas.

The reasons for alcohol misuse among the elderly are too numerous for me to go into here, but perhaps I can try to touch upon some of the more important ones.

First, something that has been stated here today already, that is expansion of abstinence for what was formerly a pattern of controlled drinking into alcohol abuse or alcoholism because of new problems emerging as a consequence of development of loneliness and isolation after retirement is a very important factor to consider.

Second, there is a lack of appreciation on the part of both patients and physicians of the enhanced vulnerability of the elderly to alcohol, something about which I will speak in more detail in a moment.

And, third, the inability of patients and physicians to appreciate changes which have occurred in aging, not only as a consequence of isolation and loneliness but very specific physiological changes.

For example, an important physiological change to note is the change in sleep patterns. Concern about altered sleep patterns is a major reason for alcohol and sedative misuse among the elderly. And it is probably unnecessary if education was sufficient. The total amount of sleep is known to decrease and the frequency of nocturnal awakening is known to increase with aging.

Instead of regarding the sleep patterns of the elderly as a disorder to be medicated by self-prescribed or prescription sedatives prescribed by a physician, it might be more constructive for those who can't sleep to read, watch television or work on some hobbies, rather than to take alcohol or drugs to fall asleep.

On the other hand, if the main reason for anxiety about altered sleep patterns is some other problem, such as increasing isolation of the elderly from a supportive and extended family, treating the alcohol abuse problem would not be as constructive as would be addressing the underlying problem itself.

Perhaps the most important misconception about aging is the widely held belief that confusion and disorientation are inevitable as one grows older. This belief persists in the face of the incontrovertable evidence of numerous elderly individuals persisting in active, productive, and creative lives. The possible causes of genuinely irreversible chronic brain syndrome in the elderly are actually very few. After Alzheimer's disease, which probably affects only a small percentage of people, and what is now called multi-infarction dementia, which is essentially cereovascular disease, and which is even rarer than Alzheimer's disease, the overall majority of so-called organic brain syndromes in the elderly are completely reversible.

Furthermore, a great many of these cases are actually due to misuse of alcohol and other sedative agents taken on the patient's own accord or by way of prescription.

This brings me to the next issue. What in fact is the incidence of alcohol use and misuse by the elderly? Are the available data valid? Keep in mind collectors of this data rely heavily on voluntary participation in interviews or with self-administered questionnaires, and this methodology has numerous limitations. Nevertheless, accepting these limitations, here are the data as they have been presented.

Drinking in the elderly is usually defined by criteria of quantity and pattern of consumption. These criteria usually follow those of the National Institute of Alcoholism and Alcohol Abuse, which defines heavy drinking as two or more drinks per day. When these prevalences are determined, alcohol consumption in the elderly is found to be consistently less than alcohol consumption by younger groups. Depending on the study, the percentage of heavy drinkers is 8 to 11 percent of males over 65 as opposed to 22 to 28 percent for males in the age group 18 to 49. Current figures for women are 2 percent of the elderly and 8 percent in the younger group.

If one accepts these figures, fewer elderly male drinkers consume quantities of alcohol sufficient to consider them heavy drinkers. And heavy drinking is even lower among elderly females.

These statistics, however, are deceptive for a number of reasons. First, there is a problem of how accurate the surveys are. Heavy drinking among the elderly may be underestimated if the elderly are much less like to be accessible to questionnaires and interview techniques. Many elderly individuals do not live in settings where these data are gathered. And more research is needed to assess the problems of heavy drinking among the elderly in settings where they are likely to be located.

More to the point are the studies of individual agencies and institutions which suggest a much higher incidence of heavy drinking among the elderly, a more accurate reflection than the estimates indicated in nationwide surveys.

Careful studies dealing with the aged in their own environment are clearly needed to deal with this issue.

The second problem concerns the definition of heavy drinking. Quantifying intake is simplistic and deceptive because elderly persons may have special problems with less alcohol. Physiological research, for instance, has shown that the amount of water in our body decreases with age. Since alcohol is distributed almost exclusively in body water, the same amount of alcohol will result in a higher concentration of alcohol in the blood and tissues of the elderly than in their younger counterparts.

Related to this difference is another overall issue involving mental abilities. Although research has shown that intelligence does not change with age, recall and recognition of memory do become somewhat less as we grow older. And it may be that alcohol, synergistically, enhances this age related effect. Since elderly alcohol users are subjected to an increased effective dose, future studies of the effect of alcohol on the elderly must assess actual impairment in social or occupational functioning.

Finally, I want to raise the general issue of treatment. What is it that we should be treating when we talk about the elderly and misuse of alcohol? Is misuse of alcohol the main problem or is it simply the act of a lack of appreciation of changes associated with aging, such as alienation, isolation, and more specifically such as the changes in sleep pattern, which I have just mentioned?

If it is misuse of alcohol, should abstinence be the goal for the elderly? Some research studies have shown that moderate controlled social drinking in a structured pattern may be a more positive solution to problems than total abstinence. This, among others, is one of the major research issues which remains to be addressed.

In summary, the problems of alcohol and other sedative misuse is inseparable. Second, it would be beneficial if there were better public and physician education as to the increased vulnerability of the elderly to alcohol and sedatives and to the alteration of sleep patterns.

The increasing isolation of the elderly in our society converts abstinence or controlled drinking to alcohol abuse and alcoholism. Anxiety about normal sleep patterns enhances alcohol and sedative misuse.

More research is needed as to the real pharmacological impact of alcohol on the elderly and the prevalence of alcoholism as to the effective delivery of treatment of these problems. Thank you.

Ms. FERRARO. Thank you very much. I am certainly grateful for your professionalism and your testimony and again your concern about the abuse of prescription drugs. Your concern that we do not separate drug abuse from alcohol abuse is certainly noted. And as I indicated before, Senator Pepper has had hearings specifically on the other and will continue to do so. Thank you very much.

Mr. PEPPER. I just want to commend Dr. Zeidenberg and Ms. Saunders for both of your excellent statements. You gave a great deal of material and we will profit by it in some future hearings we are planning on those critical subjects.

Ms. FERRARO. Thank you very much.

Our final witness—and we are going to keep an eye on the clock, because we are coming right down to the line—is the Honorable Don Nicholson, who is the Assistant Inspector General, one of the Assistant Inspector Generals, of the Department of Health and Human Services from Washington. He was formerly, until 1982, Director of the Program Validation for Health Care Financing Organization. You will forgive us, if we cannot get to questions with you after because of our time constraints, we will certainly grab a hold of you in Washington and follow up.

STATEMENT OF DON NICHOLSON, ASSISTANT INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Mr. NICHOLSON. I will submit my full text for the record and abbreviate my remarks.

Ms. FERRARO. That is fine.

Mr. NICHOLSON. My name is Don Nicholson. I am Assistant Inspector General for the Office of Inspector General in the Department of Health and Human Services. As you pointed out, Repre-

sentative Ferraro, I was previously an employee for the Health Care Financing Administration, which is the Federal agency responsible for administering medicare and the medicaid programs.

My purpose here today is to relate experiences that I am familiar with pertaining to medicare coverage and reimbursement for alcoholism treatment borne primarily out of the findings of a review to examine the appropriateness for inpatient hospital care to treat alcoholics.

The medicare program authorizes considerable coverage for the treatment of alcoholism and medical problems associated with alcoholism. The benefits and the services available for such treatment are similar to those available for coverage, under medicare, of any condition. It is important to note that alcoholism services covered under medicare must be reasonable and necessary for either the diagnosis or treatment of the patient's condition. This is a general program requirement applied to all services under medicare.

The medicare statute does not provide a specific benefit for alcoholism or for any other particular diagnosis with the single exception of end stage renal disease. Services are covered, however, because they are medically necessary and rendered in a covered setting.

By statute, medicare is primarily oriented toward covering acute conditions. Thus, the coverage of alcohol treatment is similarly focused. Coverage of alcohol treatment is available in both general and psychiatric hospitals since accepted national and international medical references have classified alcoholism as a mental disorder.

The review that I referred to earlier was conducted to determine how general medicare requirements were being applied to the coverage and reimbursement for alcoholism. The review that I am about to refer to focused on patient care exclusively in an inpatient setting.

The major findings of that review revealed that out of 1,750 patient days that were examined in six hospitals, 75 percent of those days, or about 1,300 were considered highly questionable as covered days when applying medicare criteria for reimbursement. The payment for those days represented $325,000 just for that sample. The reviewers questioned justifications provided by the hospitals for admitting patients for inpatient treatment when such treatment had failed repeatedly in the past, and when less expensive alternatives were available.

I would like to give you a couple of examples of what I am talking about. There was a 69-year-old man who was admitted to the hospital after a 4-day binge, who at the time of admission was only mildly intoxicated and whose drinking, according to the medical record, was on a very light level and in company, prior to the binge. In this instance there was really no medical indication to support the need for inpatient hospitalization for this person. Furthermore, the reviewer noted that the agent responsible for paying those medicare claims had no ability to detect these kinds of situations. The problem regarding the patient was an unnecessary hospital admission. The greater problem was that the agent paying the claim or any inpatient hospital claims had no ability to detect inappropriate admission. The result of these problems is that medi-

care funds available for needed health care services were being diverted for inappropriate care.

Another example was for a 64-year-old man admitted several times for the treatment of acute toxic hepatitis. Over a span of 18 months, he had been hospitalized five times for detoxification and rehabilitation, although in each instance he was shown to have acute toxic hepatitis.

A point to be made with this example is that often with the medicare claims under review, a false or misleading diagnosis is shown to justify payment or to allow the claim to pass certain computer checkpoints. In my opinion, these erroneous diagnoses, because they are false and misleading, can result in inappropriate reimbursement. Under medicare, they represent a serious breach on the part of the health care provider and could be subject to criminal or civil penalties.

Another issue this example illustrates is the problem of hospital readmissions. Namely the situation where individuals are checked in and out of hospitals. The fact of earlier admissions might suggest that another admission may not help to cure or improve the patient condition. There are other examples in this report that I am citing. There is another one where an individual was hospitalized 13 times over a span of 1 year at a cost to medicare of some $35,000 just for the hospital care. Added to that would be the medicare payments made for physician's services.

The Health Care Financing Administration, which is the Federal agency responsible for administering medicare is taking steps to insure that those who need alcohol detoxification and rehabilitative help actually receive what is needed. In recently revised guidelines, the Health Care Financing Administration stated in part, that there should be documentation to establish that admission to the hospital setting for alcohol rehabilitation services can reasonably be expected to result in improvement in the patient's condition.

The guidelines include a requirement that the patient's physician certify that prior treatment in an outpatient setting has not proven effective or that there are medical reasons otherwise to suggest that treatment in an inpatient setting is required.

The Health Care Financing Administration has also worked with the agents responsible for paying medicare claims to insure that the earlier deficiencies that I referred to, which caused the unnecessary hospitalization, and readmissions, do not recur. As a representative now of the Office of the Inspector General, I intend to recommend to my boss that we go back and we take a look at some of these earlier, what I consider to be serious problems, to see to what extent they might still be existing. These kinds of investigations, reviews, inspections, are necessary to preserve the integrity of these programs. Thank you.

Mr. Chairman, the major point I would like to make is that we simply cannot afford to spend scarce medicine money on health services that are not medically appropriate. We have found this to be the case, however, in paying for inpatient treatment and care for alcoholism because of program abuse on the part of the health care provider and inefficiencies on the part of agents paying medicare claims. These practices divert funds for the true health care

needs, including legitimate treatment for alcoholism of the elderly in our population.

Ms. FERRARO. Thank you. I want to say that is dynamite testimony. We will, of course, make your full statement part of the record.

[The prepared statement of Hon. Don Nicholson follows:]

PREPARED STATEMENT OF DON E. NICHOLSON, ASSISTANT INSPECTOR GENERAL FOR HEALTH FINANCING INTEGRITY, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, Members of the Committee, my name is Don Nicholson. I am here today as an Assistant Inspector General in the Office of the Inspector General, Department of Health and Human Services. I was previously an employee of the Health Care Financing Administration (HCFA), Department of Health and Human Services. In my prior capacity, as a HCFA employee, I was the Director of the Office for Program Validation and while serving in that position I was responsible for structuring and overseeing what HCFA termed program validation reviews. One such review conducted by the San Francisco regional office was done for the purpose of examining the Medicare coverage and reimbursement for inpatient treatment of alcoholism.

Mr. Chairman, my purpose here today is to relate experiences that I am familiar with pertaining to Medicare coverage and reimbursement for alcoholism treatment borne primarily out of the findings of that review. The review which was conducted in 1981 revealed a number of problems relating primarily to the appropriateness of Medicare payment for inpatient alcoholism, detoxification and rehabiliation. The report on the review has not yet been finalized. My understanding is that HCFA wants to incorporate with the report anticipated effects of prospective payment as this may relate to the major findings of the study. However, HCFA has recently improved its coverage rules which in large measure respond to many of the negative findings. I will elaborate on the specifics of the review and HCFA's subsequent action in a moment. But first I would like to make some general comments regarding Medicare coverage and reimbursement principles and how these principles apply to alcoholism.

The Medicare program authorizes considerable coverage for treatment of alcoholism and medical problems associated with alcoholism. The benefits and services available for such treatment are similar to those available for coverage under Medicare of any medical condition. It is important to note that alcoholism services covered under Medicare must be reasonable and necessary for either the diagnosis or treatment of the patient's condition. This is a general program requirement that applies to all services provided under Medicare. The Medicare statute does not provide a specific benefit for alcoholism, or any other particular diagnosis; services are covered, however, because they are medically necessary and available in a covered setting. By statute, Medicare is primarily oriented toward covering acute conditions. Thus, the coverage of alcohol treatment is similarly focused. Coverage of alcohol treatment is available in both general and psychiatric hospitals since accepted national and international medical references have classified alcoholism as a mental disorder.

The validation review that I referred to earlier was conducted to determine how these general Medicare requirements were being applied to the coverage and reimbursement for alcoholism. The review focused exclusively on patient care in an inpatient setting.

In 1980 while doing a review of a single facility on the West Coast, reviewers estimated approximately 60 percent of the inpatient stays and services examined should not have been paid for. Furthermore, in some areas of California, Professional Standard Review Organizations (PSROs)[1] were denying a high percentage of Medicare claims for inpatient alcohol treatment while in other parts of the State, very few claims were being denied. These observations suggested that a need existed for better definitions of what constituted covered care for inpatient alcoholism treatment and that there were inconsistencies on the part of those responsible for

[1] PSRO's are organized physician groups under contract with the Health Care Financing Administration (HCFA) to monitor the quality and appropriateness of inpatient hospital services. PSROs do not exist in all areas of the country and where PSROs do not exist, fiscal intermediaries, typically insurance companies under contract with HCFA, make coverage and utilization determinations on inpatient services.

making determinations on Medicare claims in the approaches being used to make those determinations.

It was thus decided to do expanded reviews in 1981. For this review 6 hospitals were selected and from those 6 hospitals, 146 inpatient hospital stays totaling 1,751 days for 104 Medicare patients formed the basis for the study. Four of the hospitals were under PSRO review and two were under fiscal intermediary review. The validation study was conducted by analysts and nurses who received consultative assistance from seven physicians experienced in utilization review of alcoholism services. The intent was to determine the extent to which Medicare payment was being made consistent with the "reasonable and necessary" guidelines embodied in the Medicare statute.

In summary, the major findings revealed that out of 1,751 patient days claimed for alcohol treatment, 75 percent or 1,315 days were highly questionable when applying Medicare coverage criteria. Payment for these disputed services amounted to $325,000. The reviewers questioned justifications provided by the hospitals for admitting patients for inhospital treatment when such treatment had failed repeatedly in the past and when less expensive alternatives were available. Let me give you a couple of examples of what I am talking about:

A 69 year old man is admitted to the hospital after a "4 day binge" who at the time of admission was only mildly intoxicated and whose drinking according to the medical record was "on a very light level and in company" prior to the "binge."

In this instance, there was really no medical indication to support the need for inpatient hospitalization for this person. However, the reviewer noted that the fiscal intermediary responsible for making payment determinations had no processes in place to select out these kind of situations. Claims for services were questioned only if the length of a patient's stay in a hospital setting exceeded a certain time period.

Another example was a 64 year old man admitted several times for the treatment of "acute toxic hepatitis." Over a span of 18 months he had been hospitalized 5 times for detoxification and/or rehabilitation. There was nothing in the medical record to support hepatitis nor for that matter were there any gross pathological findings.

A point to be made with this example is that often with the Medicare claims under review, a false or misleading diagnosis was shown to justify payment or to allow the claim to pass certain computer checkpoints. In my opinion, these erroneous diagnoses, because they are false and misleading, can result in inappropriate reimbursement. Under Medicare they represent a serious breach on the part of the health provider and could be subject to criminal or civil penalties. Another issue this example illustrates is the problem of hospital readmission, namely the situation where individuals were checked in and out of hospitals. The fact of earlier admissions might suggest that the current admission is unlikely to result in patient rehabilitation.

HCFA is taking steps to insure that those who need alcoholic detoxification and rehabilitative help actually receive what is needed. In recently revised guidelines, HCFA stated in part, that "there should be documentation to establish that admission to the hospital setting for alcohol rehabilitation services can reasonably be expected to result in improvement of the patient's condition." The guidelines include a requirement that the patient's physician certify that prior treatment in an outpatient setting has not proven effective or that there are medical reasons otherwise to suggest that treatment in an inpatient setting is required. HCFA has also worked with fiscal intermediaries and PSROs where deficiencies were noted in their coverage determination processes to correct those deficiencies. In fact, another reason for this report not being yet final is to allow HCFA to review those PSRO's and intermediaries performance to assure that proper decisions are now being made and include the results in the report. In addition, OIG is working with HCFA and the Office of General Counsel to implement the Civil Money Penalties provisions which provide for administrative and civil damages for health care providers who submit false information for the purpose of obtaining Medicare reimbursement.

It may be necessary if abuses of the type noted through this review continue for HCFA to seriously consider a limit on the number of inpatient stays for treatment of alcoholism. As a part of the research done by the HCFA validation review staff, it was noted that 26.2 percent of the admissions to a chain of alcohol rehabilitation facilities were patients who had alcohol related inpatient stays three or more times during a four year period.

Undoubtedly, some of the patients referenced in the review and others who are receiving inpatient care have benefitted from such care. Undoubtedly, there are patients who might benefit from inpatient care to a much greater extent than care on an outpatient basis or through some other alternative. From a lay persons' point of

view, however, I question whether the costs associated with examples I have cited and numerous others which make up the basis of this report's findings, can continue to justify the high cost associated with inpatient hospital care when less expensive, equally effective detoxification/rehabilitative care is available. In the Congressional Office of Technology Assessment study on alcoholism there are questions posed as to the relative medical value of inpatient vs. outpatient detoxification and rehabilitation.

Mr. Chairman, I believe HCFA should be commended for having undertaken this review. The problems noted are significant. As I referenced earlier, HCFA has already responded to improving coverage guidelines and strengthening the criteria for admissions.

I intend to recommend to the Inspector General that we conduct inspections in this area during the course of the next fiscal year to determine to what extent the report's recommendations have been implemented and to re-examine the issue of inpatient alcoholism treatment. Reviews and inspections of this type are necessary to ensure the cost effective expenditure of Medicare resources. Through such surveillance, whether done by HFCA or OIG staff, errors and inefficiences can be checked to preserve Medicare monies for the critical health care needs including alcoholism treatment for the elderly in our population.

I commend you and the Committee along with Committee staff for recognizing the significance of this issue and bringing this matter to public attention.

I would now be happy to respond to questions.

Mr. PEPPER. Mr. Nicholson, you have emphasized, I think quite well, sir, that we want to prevent unnecessary expenditures under medicare, because that is taking money away from people who need it. But if you had preventive services available under medicare, would that not save a lot of money, in the long run?

Mr. NICHOLSON. It is an open question. I know this. I know that on the basis of some examinations that have been done, with regard to one kind of service being covered under medicare and whether or not that is saving money for another kind of service, an example of that is home health. It was hoped that the home health benefits would save a lot of inpatient hospital money. I do not believe that there has been any evidence to support that specifically. It would seem logical that this would be the case.

In the case of alcoholism specifically, I know this. I know that the Health Care Financing Administration and the National Institute on Alcohol Abuse and Alcoholism are jointly engaged in a study to take a look at the various alternative delivery systems and the ways of treating the alcoholic to try to answer the kind of questions you just raised, Mr. Pepper. That study was initiated in September 1981. It is scheduled to be a 4-year study.

Mr. PEPPER. Let us take for example, giving an individual a test to see whether that individual has high blood pressure or not. Now that is not provided for at the present time under medicare. That is forbidden. I am not talking about something in a hospital. I am talking about someone coming into an agency and wanting to have their blood pressure checked. And you do not do that at the present time.

Mr. NICHOLSON. That is true.

Mr. PEPPER. It may well be if you discover an individual has high blood pressure and began the proper treatment of it, it might be that that individual could be spared a stroke, and the hospital would be spared a patient that might be in the hospital ostensibly for a good long time.

Mr. NICHOLSON. I understand your point.

Mr. PEPPER. Would you like to make any comment on the demonstration project that we have authorized by Congress, for you to

make contracts with HMO's, under which you pay the HMO 95 percent of the average expenditure by medicare per patient per year in a given area.

Now, down in Miami, we have at least 3 of those HMO's that have thousands of elderly people under medicare in their program. I am not saying whether they render good service or not. At least if you are in that program medicare saves 5 percent, only paying 95 percent of what it would otherwise ordinarily spend. So it is a savings to the Government. Those that I know of down there, one of them is a group 900 doctors that formed an HMO. Two entrepreneurs that formed an organization, HMO, and they do not require the patient to pay that deductible of $304 before they get in a hospital. They afford free choice of hospital and also free choice of doctor.

The patient does not have to pay the $75 coinsurance he must now pay to see a doctor. Now the administration has recommended that patients be required to pay a copayment in addition to the initial $304 when they are admitted to a hospital, $27 a day the first half of the month and $17 a day the last half of the month. So I know we are all concerned about reducing cost, but it looks like to me that is sort of a negative approach and I am hopeful that the 10 or 12 demonstration projects that are going on in the country will be successful. We are going to have a hearing on it shortly. Somewhere it looks like that would save money for the Government and save money for the patient and give the patient more care.

Mr. NICHOLSON. That would be the best of all worlds.

Bishop SULLIVAN. This is not a question. I just wanted to say on behalf of the people here, and I represent all of you, that we welcome this opportunity. When Geraldine scheduled this opportunity for a hearing here, I went out of my way to make sure I would be here today because I knew Congressman Pepper would be here. I think what he represents is an advocate for the seniors of this country, and not just the seniors; and it is not just because of what he does in the Congress of the United States, in terms of the programs that he has fought for and social security that he has protected he is a living example of what the rest of us should try to be.

Ms. FERRARO. I just have several announcements. First of all, these mikes have worked very, very well. We have been here before. Sometimes we have had problems. And the reason they have is because one woman went out of her way to get them for us free of charge. Her name is Kay Neil and we are very grateful to her.

Again I want to thank Janet Kennedy for allowing us the use of the center, and Bishop Sullivan for being here. The bishop is a good friend of mine. We are very, very concerned. I know he is very concerned, especially when he talks about that beautiful house, that building that we have for seniors, Congressman. There is a building over here. I wish you had time to stop by and see it. We need so much more housing like that for our senior citizens.

And, finally, let me just say that you have heard us this whole morning. This afternoon from 1 to 3 Senator Pepper and I will be at Colden Auditorium at Queens College. It will be your chance, if you want, to ask questions or make comments and let us know how

you feel. So we will be there from 1 to 3, if you would like to join us, we would love to have you.

Mr. PEPPER. Bishop Sullivan, I want to thank you for your very generous remarks. You are unofficially, if not actually, a member of our committee. We appreciate you very much. We wish you could attend every hearing that we have because your spiritual stimulation and inspiration is very meaningful to us.

The last thing is, I have attended many hearings in many parts of the country over the last several years, but I have never attended a hearing where the witnesses were better and where what they shared was more interesting, more to the point, more meaningful and more helpful than I heard here today. And I want to compliment and congratulate in the finest way Representative Ferraro who is a member of our subcommittee, for this fine job and for the fine job of getting these excellent witnesses. Geraldine, we are all proud of what you have done.

Ms. FERRARO. Thank you very much.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]